Cigna HealthCare of California, Inc.

Network

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

IMPORTANT INFORMATION ABOUT FREE LANGUAGE ASSISTANCE

If you have a limited ability to speak or read English you have the right to the following services at no cost to you:

- Access to an interpreter when you call Cigna HealthCare's Customer Services Department.
- Access to an interpreter when you talk to your doctor or health care professional.
- If you read Spanish or Traditional Chinese, you also have the right to request that we read certain documents that Cigna HealthCare has mailed to you, in your preferred language. You may also request written translation of these documents.

To inform Cigna HealthCare of your preferred written and spoken languages, your race and/or ethnicity, or to request assistance from someone who speaks your language, please call us at the telephone number on your Identification (ID) card or your customer service phone number.

We are pleased to assist you in the language you prefer and understand.

INFORMACIÓN IMPORTANTE SOBRE LA ASISTENCIA GRATUITA CON EL IDIOMA

Si su dominio para hablar o leer en inglés es limitado, usted tiene derecho a acceder a los siguientes servicios, sin ningún costo para usted:

- Acceso a un intérprete cuando se comunica con el Departamento de Servicios al cliente de Cigna HealthCare.
- Acceso a un intérprete cuando habla con su médico o con el profesional de servicios de salud.
- Si usted lee español o chino tradicional, también tiene derecho a solicitar que le leamos ciertos documentos que Cigna HealthCare le ha enviado a usted por correo, en el idioma que usted prefiera. También puede solicitar la traducción por escrito de estos documentos.

Para informarle a Cigna HealthCare el idioma escrito u oral que usted prefiere, su raza y/u origen étnico, o para solicitar ayuda de alguien que hable su idioma, por favor, llámenos al teléfono que figura en su Tarjeta de identificación (*ID*) o al teléfono del servicio de atención al cliente.

Nos complace ayudarle en el idioma que usted prefiere y entiende.

有關免費語言協助的重要訊息

只要您的英語說話或閱讀能力有限，您便有權可免費取得下列服務：

- 您打電話給 Cigna HealthCare 的客戶服務部時可使用口譯服務。
- 您與您的醫師或健康照護專業人員洽談時可使用口譯服務。
- 如果您看得懂西班牙文或繁體中文，您也有權可要求我們把 Cigna HealthCare 郵寄給您的特定文件，用您慣用的語言朗讀給您聽。您也可以索取這些文件的書面翻譯。

如果您想告訴 Cigna HealthCare 您習慣讀、說的語言、您的種族和 (或) 族裔，或想由與您說同樣語言的人來協助您，請撥您會員 (ID) 卡上的電話，或撥客戶服務部電話與我們聯絡。

我們十分樂意用您慣用且能清楚瞭解的語言來協助您。

THÔNG TIN QUAN TRỌNG VỀ DỊCH VỤ TRỢ GIÚP NGÔN NGỮ MIỄN PHÍ

Nếu khả năng nói hoặc đọc Anh ngữ của quý vị có giới hạn, quý vị có quyền được cấp miễn phí những dịch vụ sau đây:

- Có thông dịch viên giúp đỡ khi gọi cho Ban Dịch vụ hội viên của Cigna HealthCare.
- Có thông dịch viên giúp đỡ khi quý vị nói chuyện với bác sĩ của quý vị hay nhà chăm sóc sức khỏe chuyên môn
- Nếu quý vị biết đọc tiếng Tây Ban Nha hoặc tiếng Trung hoa truyền thống, quý vị cũng có quyền yêu cầu chúng tôi đọc cho quý vị nghe một số tài liệu mà Cigna HealthCare gửi qua bưu điện đến cho quý vị bằng ngôn ngữ của quý vị. Quý vị cũng có thể yêu cầu chúng tôi gửi cho quý vị bản dịch của những tài liệu này.

Để cho Cigna HealthCare biết ngôn ngữ quý vị nói và đọc, sắc dân và/hoặc chủng tộc của quý vị, hoặc để yêu cầu được một người thông thạo ngôn ngữ của quý vị giúp đỡ, quý vị hãy gọi cho chúng tôi qua số điện thoại trên thẻ hội viên hoặc gọi số điện thoại dịch vụ hội viên.

Chúng tôi luôn sẵn sàng và hân hạnh được giúp đỡ quý vị bằng ngôn ngữ quý vị muốn dùng và thông hiểu.

無料言語支援サービスに関する重要情報

英語による読み書きにご不自由を感じるお客様のために、以下のサービスを無料でご提供しています。

- Cigna HealthCareカスタマー・サービス部に電話をする際の通訳サービス。
- 担当医または医療従事者との会話を支援する通訳サービス。
- スペイン語または繁体字中国語をご利用される方を対象に、Cigna HealthCareがお手元にお送りする特定の文書をご希望の言語でお読みするサービス。該当文書の翻訳もご請求いただけます。

Cigna HealthCareにご希望言語（書面および会話）、または、該当する人種・民族の通知を行う場合、または、言語サービスをご希望の場合には、お手持ちの身分証明（ID）カード記載の電話番号、または、カスタマー・サービスの電話番号までご連絡ください。

お客様のご希望の言語で、サービスをご提供いたします。

Cigna Healthcare of California, Inc.

Update to the 2016 Evidence of Coverage

Pursuant to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and California law[1], Cigna HealthCare of California, Inc. (Plan) has revised its large group Copay plans to sub-classify the in-network mental health and substance use disorder (MH/SUD) outpatient benefits into "Office Visits" and "All Other Outpatient Services", and apply different types of cost shares to each sub-classification of benefits for plan years beginning on or after January 1, 2016.

This information updates the benefits described in an evidence of coverage (EOC) that you may have received already for 2016. The EOC is a written guide to the services the health plan covers and what you pay for services.

Changes to EOC for Mental Health and Substance Use Disorder Services

Please contact the Plan, at the number located on the back of your ID Card or www.mycigna.com, to obtain an updated 2016 EOC and for more information on the EOC changes listed below:

- Information about cost-sharing for outpatient services to treat mental health and substance use disorder conditions is in your Schedule of Copayments.
- Prior authorization requirements for MH/SUD have been clarified and are described in your Group Service Agreement.
- The language was clarified to reflect that no referral is necessary when accessing MH/SUD services.
- Covered services for mental health and substance use disorder conditions are described in your Group Service Agreement under Section IV, Covered Services and Supplies. The list of the types of covered inpatient and outpatient mental health and substance use disorder services has changed.
- The definition of "emergency medical condition" under "Covered Services and Supplies," "Emergency Services and Urgent Care" has changed to include the definition of "psychiatric emergency medical condition."

Questions

If you have questions about mental health and substance use disorder benefits, or how to access them, please contact the Plan at the number located on the back of your ID Card.

[1]California Health and Safety Code section 1374.76 Government Code sections 100503 and 100504(c), Health and Safety Code section 1366.6(e), and 10 CCR section 6460.

Addenda Required by the California Department of Managed Healthcare

For Policies Effective 7-1-2017 and Later

New Law Protects Consumers from Surprise Medical Bills

A new law created by Assembly Bill (AB) 72 (Bonta, Chapter 492, Statutes of 2016)* protects consumers from surprise medical bills when they go to in-network facilities such as hospitals, labs or imaging centers. This new consumer protection starts July 1, 2017, and makes sure consumers only have to pay their in-network cost sharing. Providers now cannot send consumers out-of-network bills when the consumer did everything right and went to an in-network facility.

Frequently Asked Questions:

What is a surprise bill, and why would I get one?

Here are some examples of when consumers have gotten surprise bills:

- A consumer had a surgery at a hospital or outpatient surgery center in their health plan network, but the anesthesiologist was not in their health plan network. Even though the consumer did not have a choice in who their anesthesiologist was, that provider sends a bill to the consumer after the surgery. This is a surprise bills.
- A consumer goes to a lab or imaging center in their health plan network for tests and the doctor who reads the results is not in their health plan network. That doctor then bills the consumer for their services creating a surprise bill for the consumer.

Under AB 72, consumers should no longer receive these surprise bills. This means when you go to a health care facility like a hospital or a lab in your health plan network, and end up with a doctor who is not in your health plan network, they cannot charge you more than you would have to pay for an in-network doctor.

Consumer Quick Facts:

- No Surprise Medical Bills: Health care consumers are no longer put in the middle of billing disputes between health plans and out-of-network providers. Consumers can only be billed for their in-network cost-sharing, when they use an in-network facility.
- Prevents Collections: Protects consumers from having their credit hurt, wages garnished, or liens placed on their primary residence.
- Helps Control Health Care Costs: Health plan payments for out-of-network services are no longer based on sticker price.

What should I pay?

Consumers who go to an in-network facility only have to pay for in-network cost-sharing (co-pays, co-insurance, or deductibles). Consumers should contact their health plan if they have questions about their in-network cost-sharing.

What is a Health Plan Network?

A health plan network is the group of doctors, hospitals and other health care providers a health plan contracts with to provide health care services to its members. These providers are called "network providers," "contracted providers" or "in-network providers." A provider who does not contract with your health plan is called an "out-of-network provider" or "non-contracted providers."

Examples of health care facilities that are in a health plan network include hospitals, ambulatory surgery centers or other outpatient settings, laboratories, and radiology or imaging centers.

What If I Received a Surprise Bill? And what if I Already Paid?

If you received a surprise bill and already paid more than your in-network cost share (co-pay, co-insurance or deductible) file a grievance/complaint with your health plan with a copy of the bill. Your health plan will review your grievance and should tell the provider to stop billing you. If you do not agree with your health plan's response or they take more than 30 days to fix the problem, you can file a complaint with the Department of Managed Health Care, the state regulator of health plans. You can file a complaint by visiting www.HealthHelp.ca.gov or calling 1-888-466-2219.

Does the New Law Apply to Everyone?

The law applies to people in health plans regulated by the Department of Managed Health Care or the California Department of Insurance. It does not apply to Medi-Cal plans, Medicare plans or "self-insured plans." If you do not know what kind of plan you are in you can call the Help Center at 1-888-466-2219 for help.

What If I Want to See a Doctor Who I Know is Out-of-Network?

If you are in a health plan with an out-of-network benefit, such as a PPO, you can choose to go to an out-of-network provider. You have to give your permission by signing a form in writing at least 24 hours before you receive care. The form should inform you that you can receive care from an in-network provider if you so choose. The form should be in your language if you speak English, Spanish, Vietnamese, Cantonese, Armenian, Russian, Mandarin, Tagalog, Korean, Arabic, Hmong, Farsi, or Cambodian.

*AB 72 protects consumers receiving non-emergency services at in-network facilities from being balanced billed by an out-of-network provider licensed by the state. California law already protects most consumers from balance billing for emergency services.

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.

*****PLEASE REFER TO "CHOOSING A PRIMARY CARE PHYSICIAN", UNDER SECTION III, AGREEMENT PROVISIONS FOR A COMPLETE DESCRIPTION OF RULES PERTAINING TO PCP SELECTION.*****

NOTICE

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

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.

Covered Services and Supplies:

Mental Health Residential Treatment Services

Benefits are payable for Mental Health Residential Treatment Services.

Inpatient Mental Health Services

Services that are provided by a Participating Hospital while you or your Dependent is confined in a Participating Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services provided by a Participating Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of sub-acute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a sub-acute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides twenty-four (24) hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A Member is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Participating Provider.

Outpatient Mental Health Services

Partial Hospitalization sessions are services that are provided for not less than four (4) hours and not more than twelve (12) hours in a twenty-four (24) hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally-authorized agency.

Inpatient Substance Use Disorder Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is confined in a Participating Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Residential Treatment services.

Substance Use Disorder Residential Treatment Services are services provided by a Participating Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of sub-acute Substance Use Disorder conditions.

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; provides a sub-acute, structured, psychotherapeutic treatment program, under the supervision of Participating Providers; provides twenty-four (24) hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A Member is considered confined in a Substance Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorder Services

Partial Hospitalization sessions are services that are provided for not less than four (4) hours and not more than twelve (12) hours in a twenty-four (24) hour period.

Mental Health and Substance Use Disorder Exclusions:

The following exclusions are hereby deleted and no longer apply:

- 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;
- Mental Health residential treatment.

Terms within the agreement:

The term "*mental retardation*" within your Group Service Agreement is hereby changed to "*intellectual disabilities*".

Visit Limits:

Any health care service billed with a Mental Health or Substance Use Disorder diagnosis, will not incur a visit limit, including but not limited to genetic counseling and nutritional evaluation.

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 endorsement, 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 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 use disorder 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.

NOTICE

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Disorder
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên của quý vị. Các trường hợp khác, xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION : Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

Thank you for choosing Cigna.

We are pleased to provide important information about your Network 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.
- **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 reminders of important annual checkups and membership discounts on nationally recognized health programs.
- **Covers emergency and urgent care, 24 hours a day, worldwide.**

It's easy to get the information you need.

- **This overview** tells you what you need to know about your plan and how to get the most from your coverage. It should answer most of your questions.
- **myCigna.com** offers a number of self-service features. You can review your benefits plan information; find participating physicians, specialists, pharmacies and hospitals closest to home or work; view the status of your claims; order a new Cigna HealthCare ID card; or change your Primary Care Physician (PCP).
- **Member Services representatives** are ready to answer your questions and help solve problems. Just call the toll-free number on your Cigna HealthCare ID card.
- **Your Cigna ID card** lists the toll-free Customer Service phone number, your PCP's name and phone number, and payment information.

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.

Table of Contents

GROUP SERVICE AGREEMENT

This Agreement discloses the terms and conditions of coverage. A prospective Member has the right to view the Agreement prior to enrollment. This Agreement should be read completely and carefully and Members with special health care needs should read carefully those sections that apply to them.

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your Agreement.

If a Member wishes additional information about the benefits provided in this Agreement the Member should contact Cigna at the toll-free number on your Cigna HealthCare ID card.

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.

Coordination of Benefits Definitions

For the purposes of "Section VI. Other Sources of Payment for Services and Supplies," the following terms have the meanings set forth below:

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;

Each type of coverage you have in these two (2) 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.

Examples of expenses or services that are not an Allowable Expense include, but are not limited to the following:

1. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
2. If you are confined to a private hospital room and no Plan provides coverage for more than the semi-private room, the difference in cost between the private and semi-private rooms is not an Allowable Expense.
3. If you are covered by two or more Plans that provide services or supplies on the basis of usual and customary fees, any amount in excess of

the highest usual and customary fee is not an Allowable Expense.

4. If you are covered by one Plan that provides services or supplies on the basis of usual and customary fees and one Plan that provides services or supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
5. If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Examples of Plan provisions are second surgical opinions and pre-certification of admissions or services.

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.

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 the Healthplan's discounted fee amount.

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 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 those services required to treat a bodily injury or a serious illness which could reasonably be expected by an enrollee to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Such services include medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance services, medical screening, examination, evaluation by a physician (or other appropriate personnel under the supervision of a physician to the extent provided by law) to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment and surgery by a physician

necessary to relieve or eliminate the emergency medical condition, within the capabilities of the facility. Examples of emergency situations include, but are not limited to, uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, active labor (which is a labor when there is inadequate time to effect safe transfer to another hospital prior to delivery, or a transfer may pose a threat to the health and safety of the mother or the unborn child), burns, cuts, and broken bones or services required by a Member to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition within the capability of the facility.

The Healthplan shall provide 24-hour access for enrollees and providers, including, but not limited to, noncontracting hospitals, to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations.

The Healthplan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee. Payment for emergency services and care may be denied only if the Healthplan reasonably determines that the emergency services and care were never performed. The Healthplan may deny reimbursement to a provider for a medical screening examination in cases when the enrollee did not require emergency services and the enrollee reasonably should have known that an emergency did not exist. The Healthplan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

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 for severe mental illness and serious emotional disturbances of a child, including behavioral health treatment, and for other mental disorders that are defined in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorder (DSM IV), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Experimental, Investigational and Unproven Services

Services provided to a Member diagnosed with cancer and accepted into an eligible Phase I through IV clinical trial for cancer shall not be considered Experimental, Investigational and Unproven Services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Independent Review Process for Experimental and Investigational Therapies (see "Section III. Agreement Provisions") and the Healthplan Medical Director to be:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical and scientific evidence. Medical and scientific evidence means:
  a. peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), and MEDLARS database Health

Services Technology Assessment Research (HSTAR);

b. medical journals recognized by the Secretary of Health and Human Services;

c. the following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;

d. findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes; and

e. peer-reviewed abstracts accepted for presentation at major medical association meetings.

- the subject of review or approval by an Institutional Review Board for the proposed use;
- the subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight;
- cosmetic surgery and treatment. Cosmetic surgery and treatment means surgery or treatment that is performed to alter or reshape normal structures of the body in order to improve appearance. Cosmetic surgery and treatment does not include gender reassignment services; or
- not demonstrated, through existing peer-reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

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 California licensed Physician charged by the Healthplan to assist in managing the quality of the medical care provided by Participating Providers in the Healthplan; or his/her 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 that are 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; or
- Services and supplies that are found to be Medically Necessary through the "Independent Medical Review for Experimental and

Investigational Therapies and Disputed Health Care Services" provision under "Section III. Agreement Provisions".

Medical Necessity may be determined prior to or after services are rendered. Some services may require a prior-authorization and others may not, but may still be reviewed for Medical Necessity when a claim is received, prior to services being covered. A participating health care professional may not charge you for a service which is later determined to be not medically necessary.

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/her 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.

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, has been designated as a Primary Care Physician by the Healthplan. Such a Physician, through an agreement with the Healthplan, provides basic health care services to you if you have chosen him/her as your Primary Care Physician (PCP). Your PCP also arranges specialized services for you.

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 the Healthplan Medical Director or your PCP in order for the services of a Participating Provider, other than the PCP, participating vision care provider or participating OB/GYN Physician, to be covered.

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.

Rider

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

Schedule of Copayments

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

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.

Serious Emotional Disturbances of a Child

Means a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

Severe Mental Illness

Shall include: Schizophrenia, Schizoaffective disorder, Bipolar disorder (manic-depressive illness), Major depressive disorders, Panic disorder, Obsessive-compulsive disorder, Pervasive developmental disorder or autism, Anorexia nervosa and Bulimia nervosa.

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 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 a Member or Membership unit must pay within a Contract Year. When the 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 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 (this limitation does not apply in the case of a pregnant woman). The immediate area, is the area in which you receive regularly scheduled, Medically Necessary care from a Participating Provider for the ongoing treatment of a medical condition. 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.

We/Us/Our

Cigna HealthCare of California, Inc.

You/Your

The Subscriber and/or any of his/her Dependents.

GSA-DEF(01) CA-F 7/17

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 legal spouse of the Subscriber, or be a domestic partner of the Subscriber that has either properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to Section 298 of the Family Code or who has a legal union validly formed in another state that is substantially equivalent to a California registered domestic partnership and you must reside or work in the Service Area; or
2. be the natural child, step-child, or adopted child of the Subscriber or eligible domestic partner, or the child for whom the Subscriber or eligible domestic partner is the legal guardian, legally placed with the Subscriber or eligible domestic partner for adoption, or supported pursuant to a court order imposed on the Subscriber or eligible domestic partner (including a qualified medical child support order), provided that the child:
   a. resides or works in the Service Area (unless the child is a full-time registered student outside the Service Area or is a child covered under a valid court order) and
      i. has not yet reached age twenty-six (26); or
      ii. the child is twenty-six (26) or older and is continuously incapable of self-sustaining employment by reason of a physically or intellectually disabling injury, illness or condition. Proof of the child's condition and dependence must be submitted, by subscriber or member, to Healthplan sixty (60) days from the date that the subscriber receives a request from the Healthplan to provide this information. Healthplan will initially request this information at least ninety days prior to the child's nineteenth (19th) birthday, and will subsequently request such proof on an annual basis after the child turns twenty-one (21).

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

A child born of a Member, when that Member is acting as a surrogate parent, is not eligible for coverage.

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. Services and Supplies under this Agreement are extended automatically to the newborn child of the Subscriber or spouse of the Subscriber from the time of that child's birth through and including the thirtieth (30) day following that birth. 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. To enroll a newborn child, you must submit an Enrollment Application, together with any additional fees due, to the Group. The effective date of coverage for your newborn child will be the date of his/her birth.

   Commencing with the thirty-first (31st) day following that birth, no services or benefits shall be extended or provided to that child, except on a fee-for-service basis, unless that child meets the eligibility requirements for Dependents and is properly enrolled as a Dependent.

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

3. Services and Supplies under this Agreement are extended automatically to a newly adopted child of the Subscriber or spouse of the Subscriber (or child placed with him/her for adoption) through and including the thirtieth (30) day following adoption or placement for adoption. If you are a Subscriber who is enrolled as a Member, you may enroll a newly adopted child or child placed for adoption within thirty-one (31) days of the date the child is adopted or placed with you for adoption. To enroll an adopted child or a child placed with you for adoption, you must submit an Enrollment Application, together with any additional fees due, to the Group. The effective date of coverage for your newly adopted child or a child placed with you for adoption will be the date of adoption or placement for adoption.

   Commencing with the thirty-first (31st) day following adoption or placement for adoption, no services or benefits shall be extended or provided to that child, except on a fee-for-service basis, unless that child meets the eligibility requirements for Dependents and is properly enrolled as a Dependent.

   If you do not enroll a newly adopted child or a child placed with you for adoption within the thirty-one (31) days, your next opportunity to enroll the child will be during the next Open Enrollment Period.

   If you are a Subscriber who is enrolled as a Member, you may enroll a child for whom you have been granted legal guardianship within thirty-one (31) days of the date you are granted legal guardianship. To enroll a child for whom you are the legal guardian, you must submit an Enrollment Application, together with any additional fees due, to the Group. If so enrolled, the effective date of coverage will be the date of court ordered legal guardianship.

   If you do not enroll a child for whom you are legal guardian within the thirty-one (31) days, your next opportunity to enroll the child will be during the next Open Enrollment Period.

C. Special Enrollment After Open Enrollment Period

There are special circumstances under which an individual who was eligible to enroll for coverage as a Subscriber, but did not do so, may be eligible to enroll himself/herself and any eligible Dependents outside of the Open Enrollment Period.

After the Open Enrollment Period, you may submit an Enrollment Application and any applicable fees, to the Group, for yourself and any eligible Dependent(s) within thirty-one (31) days of the date of the following events:

1. Marriage;
2. Birth of a dependent newborn child; or

3. Adoption of a dependent child or legal placement of a child for adoption.

If so enrolled, the effective date of coverage will be the day of the event creating eligibility.

If you do not enroll within the thirty-one (31) days of one of these events, the next opportunity for you and any eligible Dependents to enroll will be during the next Open Enrollment Period.

D. Enrollment Due to Loss of Prior Creditable Coverage

If you and/or your dependent(s) did not enroll as a Member during the Open Enrollment Period because you and/or your dependent(s) had other creditable health care coverage, you may be eligible to enroll for coverage under this Agreement if you later lose that coverage. You must submit to the Group an Enrollment Application, and any applicable fees due within thirty-one (31) days of the day that you or your dependent(s):

1. are no longer eligible for the other coverage for any reason (including separation, divorce or death of the Subscriber);
2. lost the other coverage because an employer or plan sponsor failed to pay required premium or fees; or
3. completed continuation of other coverage as provided under federal or state law.

If so enrolled, the effective date of coverage will be the first day of the month following the day on which the Healthplan received the Enrollment Application.

If these conditions are not met, or if you do not submit an Enrollment Application within thirty-one (31) days of one of these events, the next opportunity for you and any eligible Dependent(s) to enroll will be during the next Open Enrollment Period.

E. Full and Accurate Completion of Enrollment Application

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

F. Total Disability on the Effective Date of Coverage

If you are a new Subscriber or Dependent totally disabled on the effective date of your coverage and you are entitled to an extension of benefits under a prior carrier's contract or policy pursuant to Subdivision (b) of Section 1399.62 of the Health and Safety Code, the Healthplan will not provide benefits for services or expenses directly related to any conditions which caused the total disability until the earliest of the following events:

- Twelve (12) months from the termination date of the prior carrier's Agreement; or
- You are no longer totally disabled.

G. 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 (except for circumstances where you are unable to notify us of the hospitalization due to your medical condition, or other circumstances beyond your control), 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.

H. To be eligible to enroll as a Member, you must:

1. never have been terminated as a Member of any Cigna HealthCare Healthplan for any of the reasons explained in the "Section VII. Termination of Your Coverage" and
2. not have any unpaid financial obligations to the Healthplan or any other Cigna HealthCare Healthplan.

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. **TIMELY ACCESS TO CARE**

   Timely Access to Care

   The Healthplan shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the covered person's condition consistent with good professional practice. The Healthplan shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard. An enrollee has the right to request a copy of the Healthplan's policies and procedures related to Timely Access to Care. An enrollee also has the right to receive language assistance services at the time of their appointment.

   Timely Access Standards:

   - Urgent care appointments for services that do not require prior authorization within 48 hours
   - Urgent care appointments for services that require prior authorization within 96 hours
   - Non-urgent appointments for primary care within 10 business days
   - Non-urgent appointments with specialist physicians within 15 business days
   - Triage or screening services by telephone 24 hours per day, 7 days per week within 30 minutes

   For questions or additional assistance with receiving Timely Access to Care, including Language assistance services for appointments, please contact Member Services at the toll-free number on your Cigna HealthCare ID Card.
9. **Choosing a Primary Care Physician**

   PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF

PROVIDERS HEALTH CARE MAY BE OBTAINED.

Access To Reproductive Care

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health plan to ensure that you can obtain the health care services that you need.

When you enroll as a Member, you must choose a Primary Care Physician (PCP). 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. 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. Each covered Member of your family must also choose a PCP. Your PCP must be within the Healthplan's Service Area and within a thirty (30) mile radius of the Subscriber's residence or work. Your PCP is your personal doctor and serves as your health care manager. 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, including a disagreement concerning an appropriate course of treatment, but not more than once in any calendar month, but no more than 12 times per Contract Year. We reserve the right to determine the number of times during a Contract Year that you will be allowed to change your PCP.

For PCP changes that don't require review, 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 effect 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 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 about which PCPs can make Referrals to them, and then verify the information with the PCP before making your selection.

Your choice of a PCP may also affect the facilities from which you may receive services. Your choice of hospital, sub-acute or transitional care facilities, outpatient surgical facilities, or skilled nursing facilities is limited to those facilities that participate in Healthplan's provider network. The selection of facilities for inpatient care, outpatient surgery or hospitalization may be further limited to facilities affiliated with your PCP's medical group or network. Therefore, you may not have access to every health care facility in the Healthplan's Service Area. To receive a list of facilities that are contracted for sub-acute or transitional care, or for skilled nursing facilities, please contact Member Services at the toll-free number on your Cigna HealthCare ID Card.

Referrals

You must obtain a Referral from your PCP before visiting any provider other than your PCP in order for the visit to be covered. (see "Exceptions to the Referral Process" below). 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. If you request a referral from your PCP and the request is denied, you may use the Healthplan's Appeals Procedure.

If you have a condition or disease that requires specialized care over a prolonged period of time and is life-threatening, degenerative, or disabling, you shall receive a standing referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist, or the specialty care center, coordinate your health care.

The referral shall be made if your Primary Care Physician determines in consultation with the specialist, or specialty care center, if any, and the Healthplan Medical Director or his/her designee, that you need Medically Necessary continuing care from a specialist or specialty care center. The referral shall be made pursuant to a treatment plan approved by the Healthplan in consultation with the Primary Care Physician, the specialist, and you, if a treatment plan is deemed necessary. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by the Healthplan or its contracting provider. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the Primary Care Physician with regular reports on the health care provided to the Member.

After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to you in the same manner as your Primary Care Physician, subject to the terms of the treatment plan.

The determinations to deny or approve a standing referral to a specialist or specialty care center shall be made within three (3) business days of the date the request for the determination is made by you or your Primary Care Physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four (4) business days of the date the proposed treatment plan, if any, is submitted to the Healthplan Medical Director or his/her designee.

You should refer to the Healthplan's Provider Directory to obtain a list of Healthplan Providers who have demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires on-going monitoring.

10. **Procedures for Authorization of Services**

    Most PCPs belong to a network of primary care and specialty care physicians who have been given responsibility by the Healthplan for administering services within their referral network. Referrals for ambulatory care services will be initiated by your PCP and authorized in accordance with your PCP network's utilization management protocol.

    If your PCP isn't affiliated with a medical group your PCP may refer you to specialists without Healthplan approval. Other services may require prior authorization or medical necessity review in order for coverage being received.

    Authorizations can be requested from Health Care Providers to the Healthplan via telephone, facsimile, or mail. Healthplan may request medical information regarding your condition and the information surrounding the provider's determination of the Medical Necessity for the request. If the information requires Healthplan Medical Director review, Healthplan will make a decision to approve, partially approve, or deny based on Medical Necessity, requests by providers prior to, or concurrent with, the provision of health care services. The Healthplan shall respond in a timely fashion appropriate for the nature of your condition, not to exceed five (5) business days from the Healthplan's receipt of the information reasonably necessary and requested by the Healthplan to make the determination. When you face imminent and serious threat to your health, including, but not limited to, the potential loss of life, limb, or other major bodily function; or the normal timeframe for the decision

making process would be detrimental to your life or health; or could jeopardize your ability to regain maximum function, the decision to approve, modify, or deny requests shall be made in a timely fashion appropriate for the nature of your condition, not to exceed seventy-two (72) hours after the Healthplan's receipt of the request. Decisions to approve, partially approve, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to you shall be communicated to the requesting provider within twenty-four (24) hours of the decision. Decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to you in writing within two (2) business days of the decision.

Your Primary Care Physician or his/her medical group or Healthplan will notify you of the details of the authorization.

If you are not satisfied with Healthplan's decision to authorize or deny services including Second Opinions, you should make use of the Healthplan's Complaint or Appeal Procedure, which is further described under "Section III. Agreement Provisions", "When You Have a Complaint or Appeal."

If you wish to obtain a full description of the process the Healthplan uses to review, approve, modify, delay or deny requests by providers, you should contact the Healthplan at:

Cigna HealthCare of California, Inc.
National Appeals Unit (NAU)
P.O. Box 188011
Chattanooga, TN 37422

Healthplan Toll-Free number appears on your Cigna HealthCare ID card

11. **Exceptions to the Referral and Authorization Process:**

    You may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in "Section IV. Covered Services and Supplies," 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.

    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. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization.

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

    Direct Access for Mental Health and Substance Use Disorder Services

    Members covered by this plan are allowed direct access to a licensed/certified Provider for covered Mental Health and Substance Use Disorder Services. There is no requirement to obtain a referral from your Primary Care Physician.

    Prior Authorization for Mental Health and Substance Use Disorder Services

    Prior Authorization **is not** required for routine outpatient services (i.e., individual, family and group psychotherapy, medical management services, etc.) rendered by licensed or certified behavioral health professionals in an office setting and are assigned to the in-network "Office Visit" sub-classification of benefits.

Prior Authorization **is** required for All Other Outpatient services (a/k/a non-routine outpatient services, i.e. partial hospitalization, intensive outpatient services, applied Behavior Analysis, etc.) and are assigned to the in-network All Other Outpatient services sub-classification of benefits.

12. **Second Opinions**

You or your Participating Physician or Other Participating Health Professional may request a second opinion relating to a medical treatment or surgical procedure.

Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

(a) If you question the reasonableness or necessity of recommended surgical procedures.

(b) If you question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

(c) If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and you request an additional diagnosis.

(d) If the treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment.

(e) If you have attempted to follow the plan of care or consulted with your initial provider concerning serious concerns about the diagnosis or plan of care.

If you or your Participating Provider who is treating you requests a second opinion pursuant to this section, an authorization or denial shall be provided in an expeditious manner. When your condition is such that you face an imminent and serious threat to your health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to your ability to regain maximum function, the second opinion shall be authorized or denied in a timely fashion appropriate for the nature of your condition, not to exceed seventy-two (72) hours after the Healthplan's receipt of the request, whenever possible.

The applicable Copayment as indicated in the Schedule of Copayments will apply.

If you wish to obtain a description of the Healthplan's timelines for authorizing second opinions, you should contact the Healthplan at:

Cigna HealthCare of California, Inc.
National Appeals Unit (NAU)
P.O. Box 188011
Chattanooga, TN 37422

Healthplan Toll-Free number appears on your Cigna HealthCare ID card

Definition of Appropriately Qualified Health Care Professional

An Appropriately Qualified Health Care Professional is a Primary Care Physician (PCP) or Specialist Physician (Specialists) who is acting within his/her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

You may obtain a second opinion in one of the following ways:

(a) If you request a second opinion about care from your Primary Care Physician, the second opinion shall be provided by an Appropriately Qualified Health Care Professional, of your choice within the Primary Care Physician's medical group.

(b) If you are requesting a second opinion about care from a Specialist Physician, you may obtain the second opinion from any Healthplan Qualified Health Care Professional of the same or equivalent specialty of your choice, within the Healthplan's provider network. If not authorized by the Healthplan or the Primary Care Physician's medical group, additional

medical opinions not within the Primary Care Physician's medical group shall be your responsibility.

(c) If there is no Participating Provider within the Healthplan's network who meets the standard of an Appropriately Qualified Health Care Professional, then the Healthplan or the Primary Care Physician's medical group shall authorize a second opinion by an Appropriately Qualified Health Care Professional outside of the Healthplan's provider network.

In approving a second opinion either inside or outside of the Healthplan's provider network, the Participating Provider and/or the Healthplan shall take into account your ability to travel to the provider.

The Healthplan shall require the second opinion health professional to provide you and the initial health professional with a consultation report, including any recommended procedures or tests that the second opinion health professional believes appropriate.

You are limited to one (1) second medical opinion per medical treatment or surgical procedure, unless the Healthplan based on its independent determination, authorizes additional medical opinions concerning your medical condition.

If the Healthplan or the Participating Provider's medical group denies a request by you for a second opinion, they shall notify you in writing of the reasons for the denial and inform you of the right to file a grievance with the Healthplan.

13. **Continuity of Care for New and Current Members**

NOTE: The following continuity of care will not apply to a newly covered Member covered under an individual subscriber agreement who is undergoing a course of treatment on the effective date of his/her coverage for a condition described below.

Upon your request, the Healthplan shall provide or arrange for the completion of covered services from a terminated Participating Provider or non-Participating Provider if you have one of the following conditions and were receiving services from the terminated Participating Provider or non-Participating Provider at the time of the contract termination or at the time you became eligible under the Healthplan Agreement. You will qualify to receive continued services for the following conditions and specified time periods:

- **An acute condition**. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- **A serious chronic condition**. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Healthplan in consultation with you and the terminated Provider or non-Participating Provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered Member.
- **A pregnancy**. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
- **A terminal illness**. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new Member.

- The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered Member.
- Performance of a surgery or other procedure that is authorized by the Healthplan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered Member.

Provider's Responsibility. In order for a terminated Participating Provider or non-Participating Provider to continue caring for a Healthplan Member, the terminated Participating Provider or non-Participating Provider must comply with Healthplan's contractual and credentialing requirements and must meet Healthplan's standards for utilization review and quality assurance. The terminated Participating Provider or non-Participating Provider must also agree to a mutually acceptable rate of payment. If these conditions are not met, the Healthplan is not required to arrange for continuity of care.

Healthplan is not obligated to arrange for continuity of care with a terminated Participating Provider or non-Participating Provider who has been terminated for medical disciplinary reasons or who has committed fraud or other criminal activities.

Arranging for Continuity of Care. If the Member meets the necessary requirements for continuity of care as described herein, and would like to continue his/her care with a terminated Participating Provider or non-Participating Provider, the Member should call the Member Services Department at the number shown on the Member's Identification Card to make a formal request for continuity of care.

This information will be reviewed by Healthplan to determine if the Member's medical condition and the terminated Participating Provider or non-Participating Provider's status qualifies for continuity of care.

The Member will be notified if continuity of care arrangements can be made with the Member's current terminated Participating Provider or non-Participating Provider and will receive information relating to the extent and length of care that can be provided. Healthplan will make every effort to expedite the review and inform the Member of the continuity of care decision as soon as possible. If the Member does not meet the requirements for continuity of care or if the terminated Participating Provider or non-Participating Provider refuses to render care or has been determined unacceptable for quality or contractual reasons, Healthplan will work with the Member to accomplish a timely transition to another qualified Participating Provider.

To make a request for continuity of care, please contact the Member Services Department as early as possible so the review process can begin and your treatment can continue.

14. **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 Participating Provider how he/she 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 - A method of paying for healthcare services on the basis of the number of patients who are covered for specific services over a specified period of time rather than the actual cost or the number of services that are actually provided. The Healthplan agrees to pay a Participating Provider a predetermined amount on a monthly basis for agreeing to provide specified services to our Members covered by the Healthplan.

With capitation, the Participating Provider is paid the same amount for each Member regardless of how often (if at all) the Member receives care during the month and regardless of cost. Capitation offers Participating Providers a predictable

income, encourages Participating Providers to keep Members well through preventive care, eliminates the financial incentive to provide services that will not benefit the patient, and reduces paperwork.

The Healthplan does not utilize "withholds" in any of our provider contracts. A withhold is a percentage of a Participating Provider's payment that is "held back" during the year and any remaining funds may then be distributed to the provider. However, another method to compensate providers in addition to capitation is to set up risk pools for specific services. With such a method, Cigna pays a capitation payment to each Participating Provider and places additional revenue into a pool. Medical expenses for specific services are charged against the pool. Once expenses for services in the pool are covered, any positive excess funds are paid to the Participating Provider who participated in the pool. Cigna closely monitors for appropriate utilization, accessibility, availability, quality and member satisfaction.

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 Participating Provider (e.g., for a normal maternity delivery).

15. **Member Participation in Healthplan Public Policy**

The Healthplan's public policy is shaped by Member input. One-third of Our Board of Directors is made up of active Members who have access to specific Healthplan information and can vote on all issues put forth before the Board that establish public policy.

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B. Member's Rights, Responsibilities 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, (see "Section III Choosing a Primary Care Physician").
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.

You have the responsibility 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 need to reschedule or cancel an appointment.
10. Pay all charges 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: (in accordance with state and federal confidential requirements, information regarding mental illness, substance use disorder, genetic testing results, HIV and AIDS will require your prior consent to release these records):
   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 health care 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 use disorder, 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.

A. Information about Organ Donation

A simple act of generosity on your part can help alleviate one of our nation's most serious health needs. An individual who is at least eighteen (18) years of age, or an individual who is between fifteen (15) and eighteen (18) years of age may make an organ donation. Following are some statistics regarding organ donation:

- Advancements in organ transplant technology allow more patients to benefit from organ transplants. As a result, the supply of organs has not kept up with the number of patients eligible for transplantation.
- Organ donation can save many people's lives and is not limited by age.
- Each deceased donor contributes an average of three organs.
- Organ donation begins at the hospital when a patient is identified as a potential organ donor. Only those patients pronounced brain dead are considered for organ donation, though some organs are recovered from donors declared dead by traditional cardiac death criteria. Most donors die from injuries such as brain hemorrhage, motor vehicle accidents, drowning, gunshot or stab wounds, or asphyxiation.
- Once a potential organ donor has been identified, a staff member of the hospital or the organ procurement organization will contact the individual's family, which has the opportunity to donate organs. If the family consents, the organ procurement organization coordinates the organ procurement activities, including preserving the organs and arranging for the transportation of the organs to the hospital where the transplant will be performed.

The California Health and Safety Code states that an anatomical gift may be made only by one of the following ways:

- A document of gift signed by the donor.
- A document of gift signed by another individual and by two witnesses, all of whom have signed at the direction and in the presence of the donor and of each other, and state that it has been so signed.
- A document of gift orally made by a donor by means of a tape recording in his or her own voice.

One easy way you can make yourself eligible for organ donation is through the Department of Motor Vehicles (DMV). Every time a license is renewed or a new one is issued to replace one that was lost, the DMV will automatically send an organ donor card. You may complete the card to indicate that you are willing to have your organs donated upon your death. You will then be given a small dot to stick on your driver's license, indicating you have an organ donor card on file. For more information, contact the local DMV office and request an organ donor card.

B. When You Have a Complaint or 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 satisfied with the care you receive. That's why we've established a process for addressing your concerns and solving your problems.

Grievances include both complaints and appeals. Complaints can include concerns about people, quality

of service, quality of care, benefit exclusions or eligibility. Appeals are requests to reverse a prior denial, a rescission of coverage or modified decision about your care.

How to File a Grievance

By Phone: To contact us by phone, call us toll-free at the telephone number on your Cigna HealthCare identification card.

By Mail: Send written grievances to:

Cigna HealthCare of California, Inc.
National Appeals Unit
P.O. Box 188011
Chattanooga, TN 37422

We will provide you with a grievance form upon request, but you are not required to use the form in order to make a written grievance.

Online: You can download a grievance form or submit an online grievance through our Web site: http://www.Cigna.com/health/consumer/medical/state/ca.html#medical.

In Person: During normal business hours we will assist you in submitting your grievance at the following address:

400 N. Brand Boulevard, Suite 400
Glendale, CA 91203

If the Member is a minor, is incompetent or unable to exercise rational judgment or give consent, the parent, guardian, conservator, relative, or other legal representative acting on behalf of the Member, as appropriate, may submit a grievance to the Healthplan or the California Department of Managed Health Care (DMHC or "Department"), as the agent of the Member. Also, a Participating Provider or any other person you identify may join with or assist you or your agent in submitting a grievance to the Healthplan or the DMHC.

Complaints

If you are concerned about the quality of service or care you have received, a benefit exclusion, or have an eligibility issue, you should contact us to file a verbal or written complaint. If you contact us by telephone to file a complaint, we will attempt to document and/or resolve your complaint over the telephone. If we are unable to resolve your complaint the day your call was received, or if we receive your complaint in the mail, we will send you a letter confirming that we received the complaint within five (5) calendar days of receiving it. This letter will tell you whom to contact should you have questions or would like to submit additional information about your complaint. We will investigate your complaint and will notify you of the outcome within thirty (30) calendar days.

Appeals

If you are not satisfied with the outcome of a decision that was made about your care and are requesting that the Healthplan reverse it, or a rescission of coverage, you should contact us within one year of receiving the denial notice to file a verbal or written appeal. Be sure to share any new information that may support a reversal of the original decision. Within five (5) calendar days from when we receive your appeal, we will confirm with you, in writing, that we received it. The letter will tell you whom to contact at the Healthplan should you have questions or would like to submit additional information about your appeal. We will make sure your appeal is handled by someone who was not involved in the initial decision, but who has authority to take action. We will investigate your appeal and notify you of our decision, within thirty (30) calendar days of our receipt of your appeal. Only a licensed physician or licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider may deny or modify requests for authorization of health care services for a Member for reasons of Medical Necessity. You may request that the appeal process be expedited, if the time frames under this process would seriously jeopardize your life or health, would jeopardize your ability to regain maximum functionality or, if you are experiencing severe pain. A Healthplan licensed Physician or health care professional, in consultation with your treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, the Healthplan will respond verbally with a decision within three (3) calendar days, followed up in writing.

Appeal Decision Notice

Every appeal decision notice will be provided in writing or electronically and will include: (1)

information sufficient to identify the initial denial claim/decision; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a statement that the you are 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) in some cases; (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 the California ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

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

If you request that your appeal be expedited you may also ask for an expedited external Independent Medical Review at the same time, if the time to complete an expedited appeal would be detrimental to your medical condition.

Independent Medical Review

In some cases, as described below you may be eligible for an external Independent Medical Review, as described in the sections below.

If your external Independent Medical Review appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the review shall be completed within 72 hours.

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Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services

Definitions

For purposes of this section, the following definitions shall apply:

Coverage decision means the approval or denial of health care services by the Healthplan, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the Healthplan Agreement. A "coverage decision" does not encompass a Healthplan or contracting provider decision regarding a disputed health care service.

Disputed health care services means any health care service eligible for coverage and payment under the Healthplan Agreement that has been denied, modified, or delayed by a decision of the Healthplan, or by one of its contracting providers, in whole or in part due to a finding that the service is not Medically Necessary.

Medical and scientific evidence means the following sources:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR).
3. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.

4. The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information.
5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.
6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

Independent Review Process for Experimental and Investigational Therapies

A Member may seek an Independent Medical Review from the Department of Managed HealthCare's Independent Medical Review System for Experimental and Investigational Therapies when all of the following conditions are met:

1. The Member has a life-threatening or seriously debilitating condition. Life-threatening means either or both of the following:
   a. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
   b. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

   Seriously debilitating means diseases or conditions that cause major irreversible morbidity.
2. The Member's Physician certifies that the Member has a condition, as defined in paragraph 1., for which standard therapies have not been effective in improving the condition, or for which standard therapies would not be medically appropriate for the Member, or that there is no more beneficial standard therapy covered by the Healthplan than the therapy being proposed pursuant to paragraph 3.; and
3. Either:
   a. the Member's Participating Physician has recommended a drug, device, procedure or other therapy that the Participating Physician certifies in writing is likely to be more beneficial to you than any available standard therapies, or
   b. the Member, or the Member's non-Participating Physician who is a licensed, board-certified or board-eligible Physician qualified to practice in the area of practice appropriate to treat the Member's condition, has requested a therapy that, based on two (2) documents from the Medical and Scientific Evidence, as defined "Definitions" above, is likely to be more beneficial to you than any available standard therapy. The Physician certification shall include a statement of the evidence relied upon by the Physician in certifying his/her recommendation. Nothing in this subdivision shall be construed to require Healthplan to pay for the services of a non-Participating Physician provided pursuant to this subdivision, that are not otherwise covered pursuant to the Agreement.
4. The Member has been denied coverage by Healthplan for a drug, device, procedure or other therapy recommended or requested pursuant to paragraph 3; and
5. The specific drug, device, procedure or other therapy recommended pursuant to paragraph 3. would be a covered service, except for Healthplan's determination that the therapy is experimental or investigational.

   The Healthplan shall notify eligible Members in writing of the opportunity to request the independent review within five (5) business days of the decision to deny coverage.

   If the Member's physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the experts on the panel shall

be rendered within seven (7) days of the request for expedited review. At the request of the expert, the deadline shall be extended by up to three (3) days for a delay in providing the documents required. The timeframes specified in this paragraph shall be in addition to any otherwise applicable timeframes contained in the "Independent Review Process for Disputed Health Care Services" section below.

Each expert's analysis and recommendation shall be in written form and state the reasons the requested therapy is or is not likely to be more beneficial for the Member than any available standard therapy, and the reasons that the expert recommends that the therapy should or should not be provided by the Healthplan, citing the Member's specific medical condition, the relevant documents provided, and the relevant medical and scientific evidence, including, but not limited to, the medical and scientific evidence as defined above under "Definitions", to support the expert's recommendation.

Coverage for the services required under this section shall be provided subject to the terms and conditions generally applicable to other benefits under the Agreement.

The Member shall not be required to participate in Cigna's Appeals Procedure prior to requesting an Independent Medical Review from the Department of Managed Health Care's Independent Medical Review System.

The Member shall not be required to pay for the external independent review or any application or processing fees.

Independent Review Process for Disputed Health Care Services

A Member may request an independent medical review from the Department of Managed Health Care's Independent Medical Review System when the Member believes that health care services have been improperly denied, modified, or delayed by the Healthplan, or by one of its contracting providers. A decision not to participate in the Independent Medical Review Process may cause the Member to forfeit any statutory right to pursue legal action against the Healthplan regarding the disputed health care service. A Member may apply to the Department of Managed Health Care for a voluntary independent medical review when all of the following conditions are met:

1. a. The Member's provider has recommended a health care service as Medically Necessary, or

   b. The Member has received urgent care or emergency services that a provider determined was Medically Necessary, or

   c. The Member in the absence of a provider recommendation under subparagraph a. or the receipt of urgent care or emergency services by a provider under subparagraph b., has been seen by a Healthplan provider for the diagnosis or treatment of the medical condition for which the Member seeks independent review. The Healthplan shall expedite access to a Healthplan provider upon request of a Member. The Healthplan provider need not recommend the disputed health care service as a condition for the Member to be eligible for an independent review.

   For purposes of this section, the Member's provider may be a non-Healthplan provider. However, the Healthplan shall have no liability for payment of services provided by a non-Healthplan provider, except for emergency services outside the Healthplan provider network, which services are later found by the Independent Medical Review Organization to have been Medically Necessary, the director of the Department of Managed Health Care shall require the Healthplan to promptly reimburse you for any reasonable costs associated with those services when the director of the Department of Managed Health Care finds that your decision to secure the services outside of the Healthplan's provider network prior to completing the Healthplan's Appeals Procedure or seeking an Independent Medical Review was reasonable under the circumstances and the disputed health care services were a covered benefit under the terms and conditions of the Healthplan Agreement.

2. The disputed health care service has been denied, modified, or delayed by the Healthplan, or by one of its contracting providers, based in whole or in part on a decision that the health care service is not Medically Necessary.

3. The Member has filed a grievance with the Healthplan or its contracting provider pursuant to Healthplan's Appeals Procedure and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. You shall not be required to participate in the Healthplan's Appeals process for more than thirty (30) days. In the case of a grievance that requires expedited review, you shall not be required to participate in the Healthplan's Appeals Procedure process for more than three (3) days. The Department may waive the requirement that the enrollee participate in the plan's grievance process if the Department determines that extraordinary and compelling circumstances exist, which include, but are not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate, and serious deterioration of the health of the enrollee.

   A Member may apply for an independent medical review from the Department of Managed Health Care's Independent Medical Review System within six (6) months of any of the above qualifying periods or events. The director of the Department of Managed Health Care may extend the application deadline beyond six (6) months if the circumstances of a case warrant the extension.

   Coverage for the services required under this section shall be provided subject to the terms and conditions generally applicable to other benefits under the Agreement.

   The Member shall not be required to pay for the external independent review or any application or processing fees.

Department of Managed Health Care's Independent Medical Review System

If the Department of Managed Health Care finds that a Member's application for Independent Medical Review (IMR) does not meet the requirements for review under the Independent Medical Review System, the Member's application for IMR shall be reviewed by the Department of Managed Health Care under its standard Complaint process. The Department of Managed Health Care shall make the final determination regarding whether a Member's application for IMR qualifies for review under the Department's IMR or Standard Complaint process.

In any case in which a Member or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of Medical Necessity, the department shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review or pursuant to the Healthplan's Appeals procedure.

A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision. If the Healthplan, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the Agreement that applies to the Member, the statement of decision shall clearly specify the provision in the Agreement that excludes that coverage.

Upon notice from the Department of Managed Health Care that the Healthplan's Member has applied for an independent medical review, the Healthplan or its contracting providers shall provide to the independent medical review organization designated by the Department of Managed Health Care a copy of all of the following documents within three (3) business days of the Healthplan's receipt of the Department of Managed Health Care's notice of a request by a Member for an independent review:

1. A copy of all of the Member's medical records in the possession of the Healthplan or its contracting providers relevant to each of the following:
   a. The Member's medical condition.
   b. The health care services being provided by the Healthplan and its contracting providers for the condition.
   c. The disputed health care services requested by the Member for the condition.
2. Any newly developed or discovered relevant medical records in the possession of the Healthplan or its contracting providers after the initial documents are provided to the independent medical review organization shall be forwarded

immediately to the independent medical review organization. The Healthplan shall concurrently provide a copy of medical records required by this subparagraph to the Member or the Member's provider, if authorized by the Member, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

3. A copy of all information provided to the Member by the Healthplan and any of its contracting providers concerning Healthplan and provider decisions regarding the Member's condition and care, and a copy of any materials the Member or the Member's provider submitted to the Healthplan and to the Healthplan's contracting providers in support of the Member's request for disputed health care services. This documentation shall include the written response to the Member's grievance.
4. A copy of any other relevant documents or information used by the Healthplan or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the Healthplan and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of Medical Necessity. The Healthplan shall concurrently provide a copy of the documents required above, except for any information found by the director of the Department of Managed Health Care to be legally privileged information, to the Member and the Member's provider. The Department of Managed Health Care and the independent review organization shall maintain the confidentiality of any information found by the director of the Department of Managed Health Care to be the proprietary information of the Healthplan.

   Upon receipt of information and documents related to a case, the medical professional reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the Member, provider reports, as well as any other information submitted to the organization as authorized by the Department of Managed Health Care or requested from any of the parties to the dispute by the reviewers. If reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria. Following its review, the reviewer or reviewers shall determine whether the disputed health care service was Medically Necessary based on the specific medical needs of the Member and any of the following:

   1. Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
   2. Nationally recognized professional standards.
   3. Expert opinion.
   4. Generally accepted standards of medical practice.
   5. Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

   The independent medical review organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable within thirty (30) days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the director of the Department of Managed Health Care.

   If the disputed health care service has not been provided and the Member's provider or the Department of Managed Health Care certifies in writing that an imminent and serious threat to the health of the Member may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the Member, the analyses and determinations of the reviewers shall be expedited and rendered within three (3) days of the receipt of the information. Subject to the approval of the Department of Managed Health Care, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the director

of the Department of Managed Health Care for up to three (3) days in extraordinary circumstances or for good cause.

The independent medical review organization's analyses and determinations shall state whether the disputed health care service is Medically Necessary. Each analysis shall cite the Member's medical condition, the relevant documents in the record, and the relevant findings associated with the following provisions to support the determination:

1. Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
2. Nationally recognized professional standards.
3. Expert opinion.
4. Generally accepted standards of medical practice.
5. Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

The independent medical review organization shall provide the director of the Department of Managed Health Care, the Healthplan, the Member, and the Member's provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization, except in cases where the reviewer is called to testify and in response to court orders. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

The director of the Department of Managed Health Care shall immediately adopt the determination of the independent medical review organization, and shall promptly issue a written decision to the parties that shall be binding on the Healthplan. Coverage for the services required under this section shall be provided subject to the terms and conditions generally applicable to other benefits under the Agreement.

The Member shall not be required to pay for the external independent review or any application or processing fees.

FOR INFORMATION ON HOW TO ACCESS THE INDEPENDENT REVIEW PROCESS FOR EXPERIMENTAL AND INVESTIGATIONAL THERAPIES AND DISPUTED HEALTH CARE SERVICES THE MEMBER SHOULD CONTACT Cigna MEMBER SERVICES AT THE TOLL-FREE NUMBER ON YOUR HEALTHPLAN IDENTIFICATION CARD.

Member Rights Under State Law

The California Department of Managed Health Care ("Department") is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1.800.244.6224 (1.800.321.9545 (TTY) for the hearing and speech impaired) or the toll-free telephone number on your Cigna HealthCare identification card** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1.888.HMO.2219)** and

a TDD line **(1.877.688.9891)** for the hearing and speech impaired. The Department's Internet Web site **www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

You may also request a voluntary mediation with the Healthplan before exercising the right to submit a concern or appeal to the Department. If you choose to use mediation, it will not prevent you from making a concern or complaint to the Department when the mediation is completed. In order for mediation to occur, you and Healthplan each must voluntarily agree to the mediation. The Healthplan will consider each request, by you, for mediation on a case by case basis. Each side will equally share the expenses of the mediation.

If a Member is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other person acting on behalf of the patient, as appropriate, may submit a grievance or complaint, as the agent of the Member, to Healthplan or the Department. Also, a Participating Provider may join with, or assist, a Member or Member's agent in submitting a complaint to the Department and in resolving the complaint.

FOR MORE SPECIFIC INFORMATION REGARDING THE APPEALS PROCEDURE, OR IF YOU HAVE OTHER QUESTIONS, CONTACT HEALTHPLAN MEMBER SERVICES AT THE TOLL-FREE NUMBER ON YOUR HEALTHPLAN IDENTIFICATION CARD.

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Mandatory Arbitration

To the extent permitted by law the Healthplan uses binding arbitration to settle disputes, including claims of medical malpractice and disputes relating to the delivery of service under the plan. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The parties to this contract, by entering into it, are giving up their legal right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute for medical malpractice, relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, and for violations of any law(s) or statute(s) between Group, any individual(s) seeking services under the plan, whether referred to as a Member, Subscriber, Dependent, Enrollee or otherwise (whether a minor or an adult), or the heirs-at-law or personal representatives of any such individual(s), and Healthplan (including any of their agents, successors-or predecessors-in-interest or employees).

In the event the total amount of damages claimed is over $200,000, within a reasonable time after any of the above named parties has provided notice to the other of demand for arbitration of said dispute, the parties shall appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notice has been given, the two selected arbitrators shall select a neutral arbitrator and give notice of the selection thereof to the parties. In the event the total amount of damages claimed is $200,000 or less, the parties to the dispute shall, within a reasonable time, appoint a single neutral arbitrator who shall have no jurisdiction to award more than $200,000.

In cases of extreme hardship, Healthplan will assume all or a portion of a Member's share of the fees and expenses of the neutral arbitrator. Application for hardship relief will be provided to the Member upon reasonable notice being given by the Member. To request information about the hardship process or to receive a hardship application, Members should mail a request to:

Cigna HealthCare of California, Inc.
Cigna Legal Department
400 N. Brand Boulevard, Suite 400
Glendale, CA 91203

Arbitration may be initiated by a Demand to Arbitrate served on Cigna HealthCare of California identifying each individual, healthcare plan, and/or clinic to be named therein, as well as the bases of the claim. The arbitrator(s) shall hold a hearing within a reasonable time from the date of notice of selection of the neutral

arbitrator. All notices or other papers required to be served shall be served by United States Postal Service. The arbitration shall be prosecuted with reasonable diligence, compulsory, binding, and conducted and governed by the provisions of the California Code of Civil Procedure (Sections 1280-1295 and 2016-2034) and the Federal Arbitration Act (9 U.S.C. Sections 1, et seq.).

No party to this Agreement shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Agreement pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Agreement.

Binding arbitration is not mandatory for disputes pertaining to claims for benefits under the Employee Retirement Income Security Act of 1974.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) 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; (4) 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); (5) 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.

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 Cigna HealthCare of California until you have completed the Appeals processes.

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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:

- **They are Medically Necessary and not specifically excluded in this Section or in Section V.**
- **Provided by Your Primary Care Physician (PCP), or if You have received a Referral to be seen 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 "Mental Health and Substance Use Disorder Services", "Obstetrical and Gynecological Services," "Vision Care Services" and "Urgent Care."**
- **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, Residential Treatment, Outpatient Facility Services, Partial Hospitalization, Intensive Outpatient Programs, Advanced Radiological Imaging, Non-Emergency Ambulance, and Transplant Services.**
- **However, if the California Department of Managed Health Care or the Healthplan subsequently determines that care received from a non-Participating Provider was Medically Necessary and should have been provided under the terms of this Agreement, or if there were excessive delays in treatment or referrals that may have prompted the Member to seek care from a non-Participating Provider, the Healthplan will cover the cost of such care.**

Physician Services

All diagnostic and treatment services provided by Participating Physicians and Other Participating Health Professionals, including office visits, periodic health assessments, including all routine diagnostic testing and laboratory services appropriate for such examinations; non-routine diagnostic testing, including HIV testing that is not associated with a primary diagnosis; immunizations for adults as recommended by the United States Public Health Service; well-child care, including child preventive care consistent with the Recommendations for Preventive Pediatric Health Care adopted by the American Academy of Pediatrics, blood lead level screenings and routine immunizations in accordance with accepted medical practices, including immunizations for children as recommended by the American Academy of Pediatrics or State Department of Health Services; 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.

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 Line SM 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 Line SM 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.

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; 3) serious dysfunction of any bodily organ or part; or 4) a psychiatric emergency medical condition defined as a mental disorder manifested by acute symptoms that render the patient: 1) an immediate danger to himself, herself, or others; or 2) immediately unable to provide for, or utilize, food, shelter, or clothing.

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; (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; and (c) services required by a Member to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition is within the capability of the facility.

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 Line SM 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 Line SM 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 (this limitation does not apply in the case of a pregnant woman). The immediate area, is the area in which you receive regularly scheduled, Medically Necessary care from a Participating Provider for the ongoing treatment of a medical condition. 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 should submit a claim to us no later than one hundred eighty (180) 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. Please call Member Services at the toll-free number on your Cigna HealthCare ID card for information on filing a claim.

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Ambulance Service

Ambulance services to the nearest appropriate provider or facility, or such ambulance services required as a result of a 911 emergency response system request for Emergency Services.

Autistic Disorders

Charges made for professional services and treatment programs for Pervasive Developmental Disorders or Autism, including applied behavior analysis (ABA) when prior-authorized, and evidence-based behavior intervention programs, that develop or restore to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or Autism and that meet all of the following criteria:

- The treatment is prescribed by a licensed Physician or is developed by a licensed Psychologist;
- The treatment is provided under a treatment plan prescribed by a Qualified Autism Service Provider and is administered by one of the following:
  - (i) A Qualified Autism Provider.
  - (ii) A Qualified Autism Service Professional supervised and employed by a Qualified Autism Provider
  - (iii) A Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service Provider.
- The treatment plan has measurable goals over a specific time-line that is developed and approved by the Qualified Autism Provider for the specific patient. The treatment plan should be reviewed no less than every 6 months by the Qualified Autism Provider and modified when appropriate. Within the treatment plan the Qualified Autism Provider shall do all of the following:
  - (i) Describes the patient's behavioral health impairments to be treated.
  - (ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goals and objectives, and the frequency at which the patient's progress is evaluated and reported.
  - (iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorders or Autism.
  - (iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for purposes of providing/reimbursing respite care, day care or educational services and is not used to reimburse a parent for participating in the treatment program.

Autism Spectrum Disorder is a mental disorder that is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Autism Spectrum Disorder is one of several mental disorders that are classified as a Severe Mental Illness

of a Person of Any Age, for which the Plan provides diagnosis and medically necessary treatment.

Qualified Autism Service Provider means either:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agents, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.
- A person licensed as a Physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist, who designs supervises, or provides treatment provided the services are within the experience and competence of the licensee.

Qualified Autism Service Professional means an individual who meets all of the following criteria:

- Provides behavioral health treatment.
- Is employed and supervised by a Qualified Autism Service Provider.
- Provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider.
- Is a behavioral service provider approved as a vendor by the California regional center to provide services as an Associate Behavioral Analyst.

Qualified Autism Service Paraprofessional means an individual who is unlicensed and uncertified but who meets all of the following criteria:

- Is employed and supervised by a Qualified Autism Service Provider.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by a Qualified Autism Service Provider.
- Meets criteria noted in regulations required by Section 4686.3 of the Welfare and Institutions Code.
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

Cancer Clinical Trials

A Member diagnosed with cancer and accepted into a phase I through IV clinical trial for cancer shall receive coverage for all routine patient care costs related to the clinical trial if the Member's Healthplan treating physician recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Member.

The clinical trial must meet the following requirements:

- The trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.
- The treatment provided in a clinical trial must either be:
  1. Approved by the National Institutes of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the U.S. Veterans' Administration, or
  2. Involve a drug that is exempt under federal regulations from a new drug application.

Routine patient care costs are costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be covered by the Healthplan if they were not provided in connection with a clinical trial, including the following:

- Services typically provided absent a clinical trial.
- Services required solely for the provision of the investigational drug, item, device or service.
- 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.
- Reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

If the clinical trial is conducted by a non Healthplan Participating Provider, the payment shall be at the negotiated rate that the Healthplan would otherwise pay to a Healthplan Participating Provider for the same services, less any applicable Copayments and deductibles.

Note: Clinical trial providers that are not Healthplan Participating Providers may bill the Member for charges in excess of the amounts that the Healthplan is legally obligated to pay.

The Healthplan may restrict coverage for clinical trials to participating hospitals and physicians in California, unless the protocol for the trial is not provided in California.

Dental Anesthesia

Coverage will be provided for general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting.

This section shall apply only to general anesthesia and associated facility charges for only the following Members, and only if the Members meet the above criteria.

- Members who are under seven (7) years of age.
- Members who are developmentally disabled, regardless of age.
- Members whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age.

Diabetic Services

Diabetic services shall consist of diabetic outpatient self-management training, education, and medical nutrition therapy necessary to enable you to properly use the equipment, supplies, and medications. Additional diabetic outpatient self-management training, education, and medical nutrition therapy shall be provided when ordered or prescribed by your Participating Physician or Other Participating Health Professional.

Coverage will be provided for the following Medically Necessary diabetic supplies and equipment recommended or prescribed by a Participating Physician or Other Participating Health Professional and approved by Healthplan for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as Medically Necessary, even if the items are available without a prescription.

The following supplies will be provided under Durable Medical Equipment:

- Blood glucose monitors.
- Blood glucose monitors designed to assist the visually impaired.
- Insulin pumps and all related necessary supplies.
- Podiatric devices to prevent or treat diabetes-related complications.
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

Diabetic Supply Coverage

Definition of Participating Pharmacy

A Participating Pharmacy means a pharmacy which has contracted with the Healthplan to provide prescription services to Members.

Diabetic Supplies

Coverage will be provided for the following Medically Necessary diabetic supplies recommended or prescribed by a Participating Physician or Other Participating Health Professional and approved by Healthplan for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes, even if the items are available without a prescription.

- Blood glucose testing strips.
- Ketone urine testing strips.
- Lancets and lancet puncture devices.
- Pen delivery systems for the administration of insulin.
- Insulin syringes.

You will be entitled to purchase from Participating Pharmacies, as designated by Healthplan, those diabetic supplies, ordered by a Participating Physician. Diabetic supplies shall be limited to a consecutive thirty (30) day supply and shall be subject to the Copayment shown in the Schedule of Copayments.

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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 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 a change in medical condition, anatomical change and/or reasonable wear and tear. Repair or replacement of equipment used in an activity which is not its intended use or equipment which is damaged due to loss, theft or willful destruction is not covered. 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 standard item of equipment that as determined by the Healthplan Medical Director adequately meets your medical needs.

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, dialysis machines and Medically Necessary diabetic equipment and supplies.

Coverage will be provided for the following Medically Necessary diabetic equipment and supplies recommended or prescribed by a Participating Physician or Other Participating Health Professional for the management and treatment of insulin using diabetes, non-insulin-using diabetes, and gestational diabetes provided by a vendor approved by Healthplan, even if the items are available without a prescription.

- Blood glucose monitors.
- Blood glucose monitors designed to assist the visually impaired.
- Insulin pumps and all related necessary supplies.
- Podiatric devices to prevent or treat diabetes-related complications.
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

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 lift, non-portable whirlpool, 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 (provided under Diabetic Services), and needle-less injectors.
- **Other equipment:** heat lamp, heating pad, cryounits, cryotherapy machines, electronic controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, Enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment, and diathermy machines.

External Prosthetic Appliances

Purchase and fitting of external prosthetic appliances and devices that are ordered or prescribed by a Participating Physician, available only by prescription and are necessary for the alleviation or correction of illness, injury or congenital defect.

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 prosthetics.
- Terminal devices such as a hand or hook. 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;
  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 orthoses & orthotic devices:

- Prefabricated foot orthoses;
- Unless Medically Necessary, 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, except for persons with foot disfigurements;
- 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:

- Unless Medically Necessary, 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:

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

The Healthplan will provide in-network outpatient prescription drugs for all FDA approved contraceptive drugs, devices and other products for women without cost -sharing. This includes all FDA approved contraceptive drugs, devices and products available OTC as prescribed by a Member's provider; voluntary sterilization procedures; and patient education and counseling as to contraception and follow-up services related to the drugs, devices, products and procedures, including but not limited to managing side effects and counseling as to continued adherence and device insertion and removal. If the Member's health care provider determines that none of the covered methods is appropriate, coverage will be provided for any other FDA approved method prescribed for the Member by the health care provider. Benefits will be paid on the same terms and conditions applicable to all benefits. The Healthplan may only cover one FDA approved contraceptive drug, device or product at no-cost share when multiple options and/or brands are available.

Gender Reassignment

Gender reassignment surgery (male-to-female or female-to-male) including, when applicable, hormone therapy, orchiectomy, vaginoplasty (including colovaginoplasty, penectomy, labiaplasty, clitoroplasty, vulvoplasty, penile skin inversion, repair of introitus, construction of vagina with graft, coloproctostomy), vaginectomy (including colpectomy, metoidioplasty with initial phalloplasty, urethroplasty, urethromeatoplasty), hysterectomy, and salpingo-oophorectomy, as well as initial mastectomy or breast reduction.

Members diagnosed with gender dysphoria will be treated in the same manner as any other Member when a service is requested. Clinical standards will be applied consistently and the appropriate grievance, appeal and medical review process will be available to all Members. No individual, other than a licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment.

Cosmetic surgery and treatment is specifically excluded. Cosmetic surgery and treatment means surgery or treatment that is performed to alter or reshape normal structures of the body in order to improve appearance. Cosmetic surgery and treatment does not include gender reassignment services.

Genetic Testing

Genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is only covered if:

- You have symptoms or signs of a genetically-linked inheritable disease;
- 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

- 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 condition, per Contract Year for both pre- and post-genetic testing.

Health Education and Medical Social Services

Health Education Services

The Healthplan will organize, sponsor and conduct programs in health education for the benefit of all Members. Programs offered will include instructions in the appropriate use of health services; information about the health services offered by the Healthplan and the generally accepted medical standards for the use and frequency of such service; instruction in the methods each Member can take to maintain his/her own health, such as personal health care measures and nutritional education and counseling.

Medical Social Services

Healthplan shall provide support to Members dealing with the physical, emotional and economic effects of illness and disability through Medical Social Services including hospitalization planning and related family counseling, and referral to (but not payment for) services provided through community health and social welfare agencies.

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 4 hours or less. 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. Home Health Services maximums do not apply to any home health care that is provided as part of Hospice Care Services. Physical, Occupational, and other Rehabilitative Therapy services provided in the home are [not subject to the Home Health Services benefit limitations in the Schedule of Copayments.

Hospice Care 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 one (1) year or less to live if the disease follows its natural course. 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; bereavement services for surviving family members for a period of at least one (1) year after the death of the Member; 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 for curative or life-prolonging procedures;
- services for which any other benefits are payable under the Agreement;
- services or supplies that are primarily to aid you or your Dependent in daily living;
- nutritional supplements, non-prescription drugs or substances, 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 an overall written plan of care as well as palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness;
- nursing care covered on a continuous basis for as much as twenty-four (24) hours a day during periods of crises as necessary to maintain an individual at home. Either homemaker or home health aide services or both may be covered on a twenty-four (24) hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms;
- short inpatient stays that may be necessary to manage acute symptoms or due to the temporary absence, or need for respite, of a capable primary caregiver. Respite care may be provided only on an occasional basis and for not more than five (5) consecutive days at a time;
- Medical appliances and supplies, including drugs and biologicals as defined in section 1861(t) of the Social Security Act and which are used primarily for the relief of pain and symptom control related to the Member's terminal illness are covered;
- 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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Infertility Diagnosis

Diagnostic services to establish cause or reason for infertility.

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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. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Laboratory and Radiology Services

Diagnostic laboratory and radiation therapy and other diagnostic and therapeutic radiological procedures.

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.

Inpatient Hospital Services for Maternity Care shall not require prior Healthplan approval, and may not be less than forty-eight (48) hours for a normal vaginal delivery or less than ninety-six (96) hours for caesarian section, unless both of the following requirements are met:

- The decision to discharge the maternity patient and newborn prior to these time frames is made by the Participating Physician in consultation with the new mother; and
- If prescribed by the Participating Physician, Healthplan provides a follow-up visit by or to a licensed provider. The follow-up visit may be a home visit; physician visit or plan facility visit for both the new mother and the newborn within forty-eight (48) hours of discharge.

Includes providing coverage for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein program.

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Mental Health and Substance Use Disorder Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. These disorders include Severe Mental Illness of a Member of any Age, including autism, and Serious Emotional Disturbances of a Child, as identified in the most recent edition of the DSM. These disorders also include any condition identified as a "mental disorder" in the fourth edition of the DSM (DSM IV). 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 Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and 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 Use Disorder.

Inpatient Mental Health Services

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

- Inpatient mental health services: inpatient psychiatric hospitalization, short-term treatment in a crisis residential program in a licensed psychiatric treatment facility, psychiatric observation for an acute psychiatric crisis.

Outpatient Mental Health Services

Services of Participating Providers who are qualified to treat mental health when treatment is provided on an outpatient basis. Coverage includes the following treatment services:

- Mental health office visit services: individual and group mental health evaluation and treatment, psychological testing, monitoring of drug therapy;
- Mental Health intensive outpatient mental health services: short-term hospital-based intensive outpatient care/partial hospitalization, multidisciplinary treatment in an intensive outpatient psychiatric treatment program;
- Mental Health Partial Hospitalization services are services that are provided for not less than 4 hours and not more than 12 hours in a 24-hour period.

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.

Mental Health Intensive Outpatient Therapy Program

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed mental health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine (9) or more hours in a week.

Severe Mental Illness of a Member of any Age and Serious Emotional Disturbances of a Child

Outpatient Services of Participating Providers and Inpatient and Partial Hospital treatment Services by a facility designated by the Healthplan Medical Director for the diagnosis and Medically Necessary treatment of severe mental illness of a Member of any age, and of serious emotional disturbances of a child who is a Member.

Severe mental illness shall include:

- Schizophrenia.
- Schizoaffective disorder.
- Bipolar disorder (manic-depressive illness).
- Major depressive disorders.
- Panic disorder.
- Obsessive-compulsive disorder.
- Pervasive developmental disorder or autism.
- Anorexia nervosa.
- Bulimia nervosa.

Serious emotional disturbances of a child shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

Services for treatment of a pervasive developmental disorder or autism may include speech therapy, physical therapy and occupational therapy.

The Healthplan may utilize case management and utilization review techniques to manage and authorize services and to assure that only Medically Necessary services are provided under the Agreement.

Inpatient Substance Use Disorder 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.

- Inpatient substance use disorder services: inpatient detoxification, transitional residential recovery services.

Substance Use Disorder Residential Treatment Services

Services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute substance use disorder conditions. Substance Use Disorder Residential Treatment services are exchanged with Inpatient Substance Use Disorder Rehabilitation services at a rate of two (2) days of Substance Use Disorder Residential Treatment being equal to one (1) day of Inpatient Substance Use Disorder Rehabilitation Treatment.

Substance Use Disorder Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of substance use disorder; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides twenty-four (24) hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center. A person is considered confined in a Substance Use Disorder Residential Treatment Center when he is a registered bed patient in a Substance Use

Disorder Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorder Rehabilitation Services

Services for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual or Substance Use Disorder Intensive Outpatient Therapy Program.

- Outpatient substance use disorder services: outpatient evaluation and treatment for chemical dependency, individual and group chemical dependency counseling, medical treatment for withdrawal symptoms;
- Intensive outpatient substance use disorder services: day-treatment programs, intensive outpatient programs; and
- Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in a 24-hour period.

Substance Use Disorder Intensive Outpatient Therapy Program

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed substance use disorder program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine (9) or more hours in a week.

Substance Use Disorder Intensive Outpatient Therapy Program services are exchanged with Outpatient Substance Use Disorder Rehabilitation visits at a rate of one (1) visit of Substance Use Disorder Intensive Outpatient Therapy being equal to one (1) visit of Outpatient Substance Use Disorder Rehabilitation Services.

Substance Use Disorder 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 Use Disorder Services

The following are specifically excluded from Mental Health and Substance Use Disorder 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;
- Counseling for activities of an educational nature, except as specified in the "Severe Mental Illness of a Member of any Age and Serious Emotional Disturbances of a Child" section of "Section IV. Covered Services and Supplies.";
- Counseling for borderline intellectual functioning, except as specified in the "Severe Mental Illness of a Member of any Age and Serious Emotional Disturbances of a Child" section of "Section IV. Covered Services and Supplies.";
- Counseling for occupational problems;
- Counseling related to consciousness raising;
- Vocational or religious counseling;
- I.Q. testing;
- 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, except as specified in the "Rehabilitative Therapy" section of "Section IV. Covered Services and Supplies."

Nutritional Evaluation

Nutritional Evaluation and counseling from a Participating Provider when diet is a part of the medical management of a documented organic disease, including clinically severe obesity.

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. Upon the referral of the Members Participating Provider, includes coverage for an annual cervical cancer screening test which shall include the conventional Pap test, human papillomavirus screening test that is approved by the federal Food and Drug Administration, and the option of any cervical cancer screening test approved by the federal Food and Drug Administration. For these services and supplies you have direct access to qualified Participating Providers; you do not need a Referral from your PCP. If your PCP is part of a multi-specialty group medical practice, you must see an Obstetrician/Gynecologist who is part of the same group practice. Follow up care and subsequent referrals provided by the Obstetrician/Gynecologist may be subject to the utilization management program of the medical group. Authorization will be required for obstetrical and gynecological subspecialty care such as gynecologic oncology, gynecologic endocrinology and covered infertility services.

Transplant Services

Medically Necessary 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.

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 other types of organ and tissue transplants will be considered experimental and will be excluded from this Agreement on this basis. If a transplant service has been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions". From time to time the Healthplan will review developments in medical technology, and based upon generally accepted medical standards, determine if the list of covered transplants should be revised.

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 (refer to Transplant Travel Services), 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

Non-taxable 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 and lodging 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: evaluation, candidacy, transplant event, or 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); and
- lodging 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 who is at least eighteen (18) years of age.

The following are specifically excluded travel expenses:

- any expenses that if reimbursed would be taxable income;
- travel costs incurred due to travel within sixty (60) miles of your home;
- food and meals;
- 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/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available where the Member is a donor.

Oxygen

Oxygen and an oxygen delivery system. Members traveling outside their Cigna Service Area must contact their Participating Physician prior to travel so that arrangements can be made to provide the required oxygen.

Periodic Health Examinations for Adults

All routine diagnostic testing and laboratory services appropriate for such examinations including all generally accepted cancer screening tests. Includes coverage for the screening and diagnosis of prostate cancer, which includes, but is not limited to, prostate specific antigen testing and digital rectal examinations, when Medically Necessary and consistent with good medical practice.

Phenylketonuria (PKU) Testing and Treatment

Coverage for treatment of phenylketonuria (PKU) shall include those formulas and special food products that are part of a diet prescribed by a Participating Provider who specializes in the treatment of metabolic disease, provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).

Coverage pursuant to this section is not required except to the extent that the cost of the necessary formulas and special food products exceeds the cost of a normal diet. For purposes of this section, the following definitions shall apply:

1. Formula means an enteral product or enteral products for use at home that are prescribed by a Participating Provider authorized to prescribe dietary treatments, as Medically Necessary for the treatment of phenylketonuria (PKU).
2. Special food product means a food product that is both of the following:
    a. Prescribed by a Participating Provider for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.
    b. Used in place of normal food products, such as grocery store foods, used by the general population.

Reconstructive Surgery

Medically Necessary reconstructive surgery or treatment to repair or correct abnormal structures of the body caused by congenital defects, developmental abnormalities, tumors, trauma, infections, disease or the complications of Medically Necessary, non-cosmetic surgery provided that:

- the surgery or therapy restores or improves function; or

- create a normal appearance, to the extent possible; or
- reconstructive surgery or treatment is 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 non-medically necessary treatment of TMJ disorder); or
- reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or
- the surgery or therapy 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.

The Healthplan may utilize prior authorization and utilization review that may include, but not be limited to any of the following:

- Denial of the proposed surgery if there is another more appropriate surgical procedure that will be approved for you.
- Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in Cosmetic Surgery, offer only a minimal improvement in your appearance.
- Denial of payment for procedures performed without prior authorization.

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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.

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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.

GSA-BEN(09).4-A 1/14

Rehabilitative Therapy

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. This includes routine or long-term therapy provided to maintain current health status when it is medically necessary.

The following limitations and exclusions apply to Rehabilitative Therapy:

- For Rehabilitative Therapy, the Healthplan may request that your Participating Provider provide biweekly updates on your progress.
- Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living after an illness or injury.
- 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 diagnosed medical condition or injury are not covered unless determined to be Medically Necessary;
- Speech therapy or treatment for functional articulation disorder, such as correction of tongue thrust, lisp, stuttering, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury is not covered unless determined to be Medically Necessary; and
- Treatment consisting of routine or long-term therapy provided to maintain the patient's current health status is not covered unless determined to be Medically Necessary.

If any Rehabilitative Therapy has been denied on the basis of not being Medically Necessary, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions".

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.

GSA-BEN(10).2 CA-E 1/11

Outpatient Cardiac Rehabilitation Services

Phase II cardiac rehabilitation is provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a hospital-based outpatient program following an inpatient hospital discharge. The Phase II program must be directed by a Participating Provider with active treatment and EKG monitoring.

Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility, primarily to maintain the patient's status, which was achieved through Phases I and II. Phase IV is an advancement of Phase III, which includes more active participation and weight training.

GSA-BEN(10).4 1/07

Chiropractic Care Services

Diagnostic and treatment services utilized in an office setting by participating chiropractic Physicians. 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; you do not need a Referral from your PCP.

The following limitation 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 which are not within his/her 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 reoccurrence or to maintain the patient's current status; and
- Vitamin therapy.

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Screening, Diagnosis and Treatment for Breast Cancer

Screening and Diagnosis of Breast Cancer. Coverage for mammography for screening or diagnosis of breast

cancer, consistent with generally accepted medical practice and scientific evidence, will be provided when referred by your Primary Care Physician or Participating Provider (which shall include a participating nurse practitioner, participating certified nurse midwife), providing care to you and operating within the scope of practice provided under existing law.

Breast Reconstruction and Breast Prostheses. Incidental to mastectomies and lymph node dissections, the following are considered covered services and benefits: initial and subsequent reconstructive surgeries of the breast on which the mastectomy was performed or initial and subsequent prosthetic devices, and follow up care deemed necessary by the Participating Physician; two mastectomy bras per Contract Year; complications from a mastectomy, including lymphedema therapy; prosthetic devices and reconstructive surgery for a healthy breast, if in the opinion of the Participating Physician this surgery is necessary to achieve normal symmetrical appearance. The length of hospital stay associated with a mastectomy or lymph node dissection shall be determined by the Participating Physician in consultation with the patient, consistent with sound clinical principles and processes and shall not require prior Healthplan approval. As used in this section, "mastectomy" means the removal of all or part of the breast for Medically Necessary reasons.

Section V. Exclusions and Limitations

Exclusions

Unless determined to be Medically Necessary, 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; provided, however, that this exclusion shall not operate to exclude coverage for services provided to a Member confined in a city or county jail or in a juvenile facility, solely because of such confinement, or for services provided to a Member while confined in a state hospital, solely because the services were provided in a state hospital.
2. Services required by state or federal law to be supplied by a public school system or school district that are directed by or coordinated through the public school system or the school district rather than through a Participating Provider other than those services described under Section IV. Covered Services and Supplies, Autistic Disorders.
3. 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. For example, if the Healthplan determines that a Participating Provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) You are required to pay for Covered Services and Supplies (as shown on the Schedule of Copayments) without the Healthplan's express consent, then the Healthplan in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Services and Supplies, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the Participating Provider represents that You remain responsible for any amounts that this Agreement does not cover. In the exercise of that discretion, the Healthplan shall have the right to require You to provide proof sufficient to the Healthplan that You have made Your required cost share payment(s) prior to the payment of any benefits by the Healthplan.
4. 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.
5. Any services and supplies for or in connection with experimental, investigational and unproven services as defined in "Section I. Definitions of Terms Used in this Group Service Agreement."
6. Cosmetic surgery or treatment, except as specified in the "Gender Reassignment" and "Reconstructive Surgery" sections of "Section IV. Covered Services and Supplies." Cosmetic surgery or treatment is defined as surgery or treatment that is performed to alter or reshape normal structures of the body in order to improve appearance or self esteem.
7. Surgeries are excluded, unless Medically Necessary.
8. The following services are excluded from coverage regardless of clinical indications:
   - Acupressure;
   - Craniosacral/cranial therapy - Craniosacral therapy (CST), also called cranial therapy, is an unproven non-invasive treatment that utilizes diagnostic touching to detect reported pulsations and rhythms of the flow of cerebrospinal fluid to effect a release of possible restrictions without the use of forceful manipulation. CST has been utilized for a variety of both musculoskeletal and general medical conditions. Some reported clinical applications of CST include acute systemic infections, chronic pain conditions, localized infection, dysfunctions of the viscera (e.g., ulcerative bowel conditions, asthma), depression, strabismus, auditory problems, developmental delay, and autism. The safety and efficacy of this treatment has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational

Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions";

- Dance therapy;
- Applied kinesiology - Applied kinesiology is a system using muscle testing as a functional neurological evaluation. The methodology is concerned primarily with neuromuscular function as it relates to the structural, chemical and mental physiologic regulatory mechanisms. A.K., which originated within the chiropractic profession, is an approach to clinical practice, with multidisciplinary applications. The safety and efficacy of this technique has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions";
- Rolfing;
- Prolotherapy - Prolotherapy is the injection of a solution for the purpose of tightening and strengthening loose or weak tendons, ligaments or joint capsules through the multiplication and activation of fibroblasts. The safety and efficacy of this treatment has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions"; and
- Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions - Extracorporeal shock wave therapy (ESWL) is a noninvasive treatment that involves delivery of 1000 to 3000 shock waves to the painful musculoskeletal region, and has been proposed as an alternative to surgery. The mechanism by which ESWL might work to relieve pain associated is unknown and the efficacy has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions".

9. 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 provided a continuous course of dental treatment is started within six (6) months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least fifty (50%) percent bony support and are functional in the arch.
10. Medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based scientific literature and scientifically-based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:
    - 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, unless Medically Necessary or as specified in the "Reconstructive Surgery" section of "Section IV. Covered Services and Supplies"; and
    - Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
11. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government

licenses, and court ordered, forensic, or custodial evaluations.

12. 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."
13. Infertility services, infertility drugs, surgical or medical treatment programs for infertility.
14. 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.
15. Reversal of male and female voluntary sterilization procedures.
16. Treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation. However, Medically Necessary treatment and penile implants are covered when an established medical condition is the cause of erectile dysfunction.
17. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
18. Non-medical counseling or ancillary services including but not limited to, Custodial Services, education, training, vocational rehabilitation, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back-to-school, return-to-work services, work hardening programs and driving safety. Behavioral training and services, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, or intellectual disabilities are also excluded except as specified in the "Severe Mental Illness of a Member of any Age and Serious Emotional Disturbances of a Child" section of "Section IV. Covered Services and Supplies."
19. Consumable medical supplies other than ostomy supplies, urinary catheters and diabetic supplies. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies including skin preparations, except as specified in the "Inpatient Hospital Services", "Outpatient Facility Services", "Diabetic Services", "Diabetic Supply Coverage", "Durable Medical Equipment" and "Home Health Services", sections of "Section IV. Covered Services and Supplies."
20. Private hospital rooms and/or private duty nursing except as provided in the "Home Health Services" section of "Section IV. Covered Services and Supplies." or unless determined to be Medically Necessary by the Healthplan Medical Director in consultation with the Member's treating Physician.
21. 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.
22. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, orthotics, elastic stockings, garter belts, corsets, dentures and wigs.
23. Corrective orthopedic shoes, unless medically necessary or as specified in the "Orthoses and Orthotic Devices" section of "Section IV. Covered Services and Supplies."
24. 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.
25. 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.
26. Routine refraction.
27. Eyeglass lenses and frames and contact lenses (except for the first pair of contacts for treatment of keratoconus or post-cataract surgery).
28. Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
29. Treatment by acupuncture.
30. All prescription drugs, non-prescription drugs, and investigational and experimental drugs (except as specified in "Independent Medical Review for

Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions"), and "Section IV. Covered Services and Supplies."

31. 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.
32. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
33. Dental implants for any condition.
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, except as provided in the "Genetic Testing" section of "Section IV. Covered Services and Supplies."
35. 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.
36. Blood administration for the purpose of general improvement in physical condition.
37. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
38. Cosmetics, dietary supplements and health and beauty aids.
39. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism and as specified under the "Phenylketonuria (PKU) Testing and Treatment" provision of Section IV. Covered Services and Supplies.
40. Massage therapy.

In addition to the provisions of this "Exclusions and Limitations" section , you will be responsible for the actual cost the Healthplan paid 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 or personnel 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. Under these extreme circumstances, the Member is advised to seek Emergency Services at the nearest emergency facility. The Healthplan will provide coverage and reimbursement as described in the Emergency Services and Urgent Care Section of the Agreement.

Section VI. Other Sources of Payment for Services and Supplies

Subrogation

If you are injured or rendered ill under circumstances which create a liability for a third party to pay claims or damages to you, we are subrogated to all rights, claims, or interests which you may have against such third party and shall have automatically, without the need to file with such third party or with a tribunal or court of competent jurisdiction, a lien upon the portion of the proceeds of any recovery from such third party representing the damage award you received for Medical and Hospital services provided by the Healthplan as follows:

- We have the right to recover from the third party the actual cost the Healthplan has paid, for care which we have provided for you; and
- We have the right to recover from the third party to the extent of actual payments that we have paid for Services and Supplies and not rendered services. If permitted by applicable state or federal law, we may require you, your guardian, personal representative, estate, Dependents, or survivors, as appropriate, to assign your claim or cause of action against the third party to us and to execute and deliver such instruments to secure our right to that claim.

You must assist the Healthplan in pursuing any subrogation rights by providing requested information.

Reimbursement

If you receive any payment from any third party, including, but not limited to, any worker's compensation fund or carrier, Medicare, a tort feasor, or any other insurance carrier, but excluding Medi-Cal, for Services and Supplies either rendered or paid by us, we have the right to receive reimbursement from you to the extent that you have received payment as follows:

- We have the right to receive reimbursement from you to the extent of the actual cost the Healthplan has paid for your care and treatment which we have directly rendered or arranged to be rendered for you; and
- We have the right to receive reimbursement from you to the extent that we have paid for Services and Supplies and not rendered services.

If you are not reimbursed from any third party because you knowingly chose not to apply for, or to reject, or to waive coverage, then you will be responsible for payment of all expenses for services rendered on account of such injury or illness. In addition, you will be obligated to fully cooperate with us in any attempts to recover such expenses from your employer if your employer failed to take the steps required by law or regulation to obtain such coverage.

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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:

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;

Each type of coverage you have in these two (2) 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.

Examples of expenses or services that are not an Allowable Expense include, but are not limited to the following:

1. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
2. If you are confined to a private hospital room and no Plan provides coverage for more than the semi-private room, the difference in cost between the private and semi-private rooms in not an Allowable Expense.
3. If you are covered by two or more Plans that provide services or supplies on the basis of usual and customary fees, any amount in excess of the highest usual and customary fee is not an Allowable Expense.
4. If you are covered by one Plan that provides services or supplies on the basis of usual and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
5. If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Examples of Plan provisions are second surgical opinions and pre-certification of admissions or services.

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. MEDICARE ELIGIBLES

Cigna will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

(a) **a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;**

(b) **a former Employee's Dependent, or a former Dependent spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;**

(c) **an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;**

(d) **the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;**

(e) **an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;**

(f) **an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage renal disease after that person has been eligible for Medicare for 30 months.**

Cigna will assume the amount payable under:

- **Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.**
- **Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.**
- **Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.**

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

Section VII. Termination of Your Coverage

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

Termination For Cause

Upon written notice to the Group and you, we may terminate your coverage or your Membership Unit's coverage for cause if any of the following events occur:

1. For nonpayment of the required premiums by You or the Group, if You or the Group has been notified and billed for the charge and at least a 30-day grace period has elapsed since the date of notification. Coverage will continue to be provided as required by the Agreement during the 30-day grace period described above;
2. The Healthplan demonstrates fraud or an intentional misrepresentation of material fact under the terms of the Agreement by You or the Group;
3. A violation of a material contract provision relating to employer contribution or group participation rates by the Group;
4. If the Healthplan ceases to provide or arrange for the provision of health benefits for new or renewing accounts in the group market; and
5. If the Healthplan withdraws a health benefit plan from the market, provided the following conditions are satisfied:
    a. 90 day notification is provided to the Group and all affected Subscriber's;
    b. the Healthplan makes available to the Group and all affected Subscriber's all health benefit plan's available to new group business; and
    c. the Healthplan acts uniformly without regard to the claims experience of the Subscriber, Dependent or Group or any health-status related factor relating to enrollees or potential enrollees.

Any person whose coverage is terminated under this section may have such termination reviewed by using the Healthplan Appeals process.

If you believe your coverage has been terminated or not renewed because of your health status or requirements for health care services and supplies, you may request a review by the director of the California Department of Managed Health Care or use the Healthplan Appeals process.

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 Member

If you desire to terminate Healthplan coverage, you should contact your Group for the Group's policies and procedures for terminating or changing health coverage outside of designated enrollment periods

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) 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 thirty (30) 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.
6. **Termination Due to a Change in Group's Size.** The Agreement may be terminated by Healthplan upon thirty (30) days prior written notice to Group if, at anytime, it is determined that Group's size has changed, making Group eligible for the small group reform product, as determined by the applicable state law.
7. **Termination in Accordance with State and/or Federal law.** We may terminate this Agreement upon prior notice to the Group in accordance with any applicable state and/or federal law.

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 if you or the Group has been notified and billed for the charge and at least a 30-day grace period has elapsed since the date of notification. Coverage will continue to be provided as required by the Agreement during the 30-day grace period described above.

Notice of Termination to Members

If this Agreement is terminated for any reason in this section, the notice of termination of the Agreement or of Member coverage under the Agreement shall be mailed by the Healthplan to the Group or to the Subscriber, as applicable. Such notice shall be dated and shall state:

1. The cause for termination, with specific reference to the applicable provision of the Agreement;
2. The cause for termination was not the Subscriber's or a Member's health status or requirements for health care services;
3. The time the termination is effective;
4. The fact that a Subscriber or Member alleging that the termination was based on health status or requirements for health care services may request a review of the termination by the director of the California Department of Managed Health Care;
5. In instances of termination for non-payment of fees, that receipt by the Healthplan of any such past due fees within fifteen (15) days following receipt of notice of termination will reinstate the Agreement as though it had never been terminated; if payment is not made within such fifteen (15) day period a new application will be required and Healthplan shall refund such payment within twenty (20) business days;
6. Any applicable rights Members may have under the "Continuation of Coverage" Section.

Group shall be responsible for notifying its Members, including the custodial non-covered parent of a Dependent child and the non-custodial parent providing coverage pursuant to a valid court order when termination of coverage occurs.

Review of Termination

If your coverage under this Agreement is terminated, you may request the Director of the Department of Managed Health Care of the State of California to review such termination action taken by the Healthplan and/or the Group. Such review opportunity is provided for under Section 1365(b) of the California Health and Safety Code.

Responsibility for Payment

The Group shall be responsible for the payment of all Prepayment Fees due through the date on which coverage ceases. Please contact your employer for information regarding any sums to be withheld from your salary or to be paid by you

to your employer or Agreement holder. 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.

Return of Prepayment Fees

In the event of any termination of the Agreement or of Member coverage for any reason, the Healthplan shall, within thirty (30) days following the effective date of such termination, return to the Group or the Subscriber, as applicable, the pro rata portion of any Prepayment Fees which corresponds to any unexpired period for which payment had been received, together with amounts due on claims, if any, less any amounts due to the Healthplan.

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

Upon request, 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 for cause or 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;
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.

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Section VIII. Continuation of Coverage

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Continuation of Group Coverage under COBRA

If an employer is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), an employer must give its employees and dependents the right to continue their group health care benefits. A person who would otherwise lose coverage as a result of a qualifying event is generally entitled to continue the same benefits that were in effect the day before the date of the qualifying event. Coverage may be continued under COBRA only if the required premiums are paid when due and will be subject to future plan changes.

IMPORTANT NOTICE TO INDIVIDUALS WHO BEGIN RECEIVING COBRA COVERAGE ON OR AFTER JANUARY 1, 2003.

The Healthplan shall offer an enrollee who has exhausted continuation coverage under COBRA the opportunity to continue coverage under Cal-COBRA for up to 36 months from the date the enrollee's continuation coverage began, if the enrollee is entitled to less than 36 months of continuation coverage under COBRA. See "Continuation of Group Coverage under Cal-COBRA" for a complete description of Cal-COBRA.

Qualifying Events for Continuation of COBRA Coverage

A **qualifying event** is any of the following:

- termination of the Subscriber's employment (other than for gross misconduct) or reduction of hours worked so as to render the Subscriber ineligible for coverage;
- death of the Subscriber;
- divorce or legal separation of the Subscriber from his or her spouse;
- loss of coverage due to the Subscriber becoming entitled to Medicare;
- a Dependent child ceasing to qualify as an eligible Dependent under the plan; or
- if the plan provides coverage for retired Subscribers and eligible Dependents, a qualifying event will also mean a substantial loss of that coverage due to the employer filing for Chapter 11 Bankruptcy. (The substantial loss can occur within one year before or after the filing for Chapter 11 Bankruptcy.)

Election/Notice Requirements

When there is a divorce or legal separation or a child ceases to qualify as an eligible Dependent, the Subscriber or eligible Dependent is responsible for notifying the employer within 60 days after the date of such qualifying. If the employer is not so notified, the person will not be given the opportunity to continue coverage.

After notification of his or her COBRA rights, the Subscriber or eligible Dependent has a limited amount of time to elect continuation. Continued health care is not automatic.

Continuation of COBRA benefits must be elected within 60 days of the later of the following:

- the date the Subscriber or eligible Dependent loses coverage as a result of the qualifying event; or
- the date the Subscriber or eligible Dependent is notified by the employer of the right to continued coverage.

Notice of the right to continue coverage to your spouse will be deemed notice to any Dependent child residing with your spouse.

COBRA Premium Payments

The Subscriber or eligible Dependent may be required to pay a premium to continue coverage. If the Subscriber or eligible Dependent elects to continue coverage, the Subscriber or eligible Dependent will have 45 days from the date of election to pay the initial premium due. All subsequent premiums will be due on a monthly basis. There is a 30 day grace period to pay premiums. If the premium is not paid before the

expiration of the grace period, COBRA continuation benefits will terminate at midnight at the end of the period for which premium payments were made.

Continuation Period for Subscriber and Dependent(s)

If elected, the maximum period of continued coverage for a qualifying event involving termination of employment or reduced working hours is 18 months from the date of the qualifying event. However, if a second qualifying event occurs (such as a divorce or death of the Subscriber) within this 18 month period, the period of coverage for any affected Dependent may be extended to up to 36 months from the date of the initial qualifying event.

If a covered Subscriber has a qualifying event (termination of employment or reduction in hours worked) and he/she had become entitled to Medicare before the date of this qualifying event, then;

- the Subscriber may continue the group health coverage for up to 18 months from the date of termination or reduction in hours worked, and
- any other qualified beneficiary (the spouse and/or children) will be entitled to the greater of (i) 36 months from the date the Subscriber first became entitled to Medicare, or (ii) 18 months from the covered Subscriber's termination or reduction in hours.

The maximum period of continued benefits for a qualifying event involving retired Subscribers of employers under Chapter 11 Bankruptcy and their Dependents will be:

- the date of death of the retired Subscriber; or
- for a surviving spouse or eligible Dependent, 36 months after the date of death of the retired employee.

For all other qualifying events, the maximum period is 36 months. Other events will cause COBRA benefits to end sooner and this will occur on the earliest of any of the following:

- the date the employer ceases to provide any group health plan to any employee;
- the end of the period for which premium payments were made, if the qualified beneficiary ceases to make payments or fails to make timely payments of a required premium, in accordance with the terms and conditions of the Agreement;
- the first day after the date of election on which the qualified beneficiary first becomes covered under any other group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition for such person; or the date such exclusion or limitation no longer applies to the Subscriber or Dependent;
- the first day after the date of election on which the qualified beneficiary first becomes entitled to Medicare (except for a Chapter 11 Bankruptcy qualifying event); or
- with respect to a qualified beneficiary whose coverage is being extended for the additional 11 months as described below, coverage will terminate on the first day of the month that is more than 30 days after the date in which the disabled individual is no longer disabled for Social Security purposes.

Continuation Coverage for Totally Disabled Individuals

If a qualified beneficiary is totally disabled under the Social Security Act on the date of the qualifying event, or at any time during the first 60 days of continued coverage, the 18 month period may be extended to up to 29 months. If there are non-disabled family members of this qualified beneficiary who have elected COBRA continuation coverage, they are also entitled to this additional 11 months of coverage. In order for this additional 11 months of coverage to be effective, the Subscriber or eligible Dependent must provide the employer with a copy of the Social Security Administration's determination of total disability within 60 days of receiving such notice. The notice must also be provided to the employer within the initial 18 months of COBRA continuation coverage.

If the Agreement is terminated and replaced by another group health plan, you may elect to maintain COBRA Continuation under the replacement plan.

If the plan provides for a conversion privilege, the plan must offer this option within the 180 days of the end of

the maximum period. However, no conversion will be provided if the qualified beneficiary does not actually maintain COBRA coverage to the expiration date.

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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Continuation of Group Coverage under Cal-COBRA

This section shall apply to the Group and its Members if the Group is subject to Cal-COBRA law. Cal-COBRA law applies to any small employer that employed 2 to 19 eligible employees on at least 50% percent of its working days during the preceding calendar year, or, if the employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar quarter.

Cal-COBRA also applies to groups that employ 20 or more employees if the individual began receiving COBRA coverage on or after January 1, 2003. The maximum periods of continued coverage for a qualifying event under federal COBRA will be extended to the maximum periods of continued coverage under Cal-COBRA as described below.

Under the requirements of Cal-COBRA, an employer must give notice to its employees and dependents of the right to continue their group health care benefits. A person who would otherwise lose coverage as a result of a qualifying event is generally entitled to continue the same benefits that were in effect the day before the date of the qualifying event. Coverage may be continued under Cal-COBRA only if the required premiums are paid when due and will be subject to future plan changes.

Qualifying Events for Continuation of Cal-COBRA Coverage

A **qualifying event** is any of the following:

- termination of the Subscriber's employment (other than for gross misconduct) or reduction of hours worked so as to render the Subscriber ineligible for coverage;
- death of the Subscriber;
- divorce or legal separation of the Subscriber from his or her spouse;
- loss of coverage due to the Subscriber becoming entitled to Medicare;
- a Dependent child ceasing to qualify as an eligible Dependent under the plan.

Notification Requirements

The Group will notify the Healthplan (or an administrator acting on the Healthplan's behalf) in writing, of termination or reduction of hours with respect to any Subscriber who is employed by the Group, within 30 days of the date of the qualifying event. You may be disqualified from receiving Cal-COBRA continuation coverage if the Group does not provide the required written notification to the Healthplan (or an administrator acting on the Healthplan's behalf).

The Group shall also notify the Healthplan (or an administrator acting on the Healthplan's behalf) in writing, within 30 days of the date, when the Group becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1161 et seq., or when the Group becomes subject to federal COBRA requirements.

To be eligible for continuation coverage, for any of the following qualifying event(s) the Subscriber or eligible Dependent must notify the Healthplan (or an administrator acting on the Healthplan's behalf) in writing of such qualifying event within 60 days after the event occurs:

- death of the Subscriber;
- divorce or legal separation of the Subscriber from his or her spouse;
- loss of coverage due to the Subscriber becoming entitled to Medicare;
- a Dependent child ceasing to qualify as an eligible Dependent under the plan.

If you do not notify the Healthplan (or an administrator acting on the Healthplan's behalf) in writing within 60 days of the qualifying event(s), you will be disqualified from receiving Cal-COBRA continuation coverage.

Once notified of the qualifying event, the Healthplan (or an administrator acting on the Healthplan's behalf) will send you the necessary benefit information, premium information, enrollment form and notice requirements within 14 days after receiving notification of the qualifying event from the Group or you. The information shall be sent to the qualified beneficiary's last known address. Notice of the right to continue coverage to your spouse will be deemed notice to any Dependent child residing with your spouse.

Formal Election

To continue group coverage under Cal-COBRA you must make a formal election by submitting a written request to the Healthplan (or an administrator acting on the Healthplan's behalf) at Cigna, Attn: State Continuation Unit, P.O. Box 2010, Concord, NH 03302. The written request must be delivered by first-class mail, certified mail or other reliable means of delivery within 60 days of the later of the following dates:

- the date of the qualifying event;
- the date the qualified beneficiary receives notice of the ability to continue group coverage as provided above; or
- the date coverage under the Group's health plan terminates or will terminate by reason of the qualifying event.

If a formal election is not received by the Healthplan (or an administrator acting on the Healthplan's behalf) within this time period, the otherwise qualified beneficiary(ies) will not receive Cal-COBRA benefits.

Cal-COBRA Premium Payments

To complete the election process, you must make the first required premium payment no more than 45 days after submitting your completed application to the Healthplan (or an administrator acting on the Healthplan's behalf). All subsequent premiums will be due on a monthly basis. Your first premium payment should be delivered to the Healthplan (or an administrator acting on the Healthplan's behalf) at Cigna, Attn: State Continuation Unit, P.O. Box 2010, Concord, NH 03302 by first-class mail, certified mail or other reliable means of delivery. The first premium payment must satisfy any required premiums and all premiums due. Failure to submit the correct premium amount within the 45 day period will disqualify the qualified beneficiary from receiving Cal-COBRA coverage. There is a 30 day grace period to pay subsequent premiums. If the premium is not paid before the expiration of the grace period, Cal-COBRA continuation benefits will terminate at midnight at the end of the period for which premium payments were made.

Continuation Period for Subscriber and Dependent(s)

If elected, the maximum period of continuation coverage for a qualifying event is 36 months from the date the qualified beneficiary's benefits under the contract would have otherwise terminated because of the qualifying event.

Other events will cause Cal-COBRA benefits to end sooner and this will occur on the earliest of any of the following:

- the date the employer ceases to provide any group health plan to any employee;
- the end of the period for which premium payments were made, if the qualified beneficiary ceases to make payments or fails to make timely payments of a required premium, in accordance with the terms and conditions of the Agreement;
- the first day after the date of election on which the qualified beneficiary first becomes covered under any other group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition for such person; or the date such exclusion or limitation no longer applies to the Subscriber or Dependent;
- the first day after the date of election on which the qualified beneficiary first becomes entitled to Medicare.
- the coverage for a qualified beneficiary that is determined to be disabled under the Social Security Act will terminate as described below.

- The qualified beneficiary moves out of the Healthplan's Service Area or the qualified beneficiary commits fraud or deception in the use of Healthplan services.

Continuation Coverage for Totally Disabled Individuals

A qualified beneficiary who is eligible for continuation coverage due to termination of the Subscriber's employment (other than for gross misconduct) or reduction of hours worked so as to render the Subscriber ineligible for coverage and who is totally disabled under the Social Security Act during the first 60 days of continuation coverage is entitled to a maximum period of 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event. The Subscriber or eligible Dependent must provide the Healthplan (or an administrator acting on the Healthplan's behalf) with a copy of the Social Security Administration's determination of total disability within 60 days of the date of the determination letter and prior to the end of the original 36 month continuation coverage period in order to be eligible for coverage pursuant to this paragraph. If the qualified beneficiary is no longer disabled under the Social Security Act, the benefits provided in this paragraph shall terminate on the later of 36 months after the date the qualified beneficiary's benefits under the Agreement would otherwise have terminated because of a qualifying event, or the month that begins more than 31 days after the date of the final determination under Social Security Act that the qualified beneficiary is no longer disabled. The qualified beneficiary eligible for 36 months of continuation coverage as a result of a disability shall notify the Healthplan (or an administrator acting on the Healthplan's behalf) within 30 days of a determination that the qualified beneficiary is no longer disabled.

Continuation of Coverage Upon Termination of Prior Group Health Plan

The Group shall notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered as specified above, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later.

The Healthplan (or an administrator acting on the Healthplan's behalf) shall provide to the employer replacing a health care service plan contract issued by the Healthplan, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the Healthplan reasonably required to administer the notification requirements of this Notification section.

The Group shall notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator, may provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by this Notification section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified beneficiaries who are enrolled in the plan and those qualified beneficiaries who have been notified as specified in this Cal-COBRA section of their ability to continue their coverage and may still elect coverage within the specified 60 day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the employer by the Healthplan (or an administrator acting on the Healthplan's behalf), currently providing continuation coverage to the qualified beneficiary. The successor plan shall not be obligated to provide this information to qualified beneficiaries if the employer or prior plan fails to comply with this section.

If the plan provides for a conversion privilege, the plan must offer this option within the 180 days of the end of the maximum period. However, no conversion will be provided if the qualified beneficiary does not actually maintain Cal-COBRA coverage to the expiration date.

IMPORTANT NOTICE - Cal-COBRA BENEFITS WILL ONLY BE ADMINISTERED ACCORDING

TO THE TERMS OF THE CONTRACT. THE HEALTHPLAN WILL NOT BE OBLIGATED TO ADMINISTER, OR FURNISH, ANY CAL-COBRA BENEFITS AFTER THE CONTRACT HAS TERMINATED.

Continuation after COBRA or Cal-COBRA under California Law

Eligibility must be met prior to January 1, 2005, to be eligible for the following benefits:

Upon exhaustion of COBRA or Cal-COBRA your former employer shall notify you of the availability of this Continuation after COBRA or Cal-COBRA coverage in accordance with Section 2800.2 of the Labor Code.

For purposes of this subsection only, "spouse" will also include a former spouse who is widowed or divorced.

If a Subscriber has elected COBRA or Cal-COBRA coverage, was at least sixty (60) years old and was employed by Group for at least five (5) years as of the date of termination of employment, then, if COBRA or Cal-COBRA benefits expire at the end of applicable period, Subscriber may elect to continue to receive the same benefits, for Subscriber and/or Subscriber's spouse, upon the following conditions:

- The Subscriber or the Subscriber's spouse must notify the Healthplan in writing within thirty (30) days of the expiration of COBRA or Cal-COBRA benefits that continuation coverage is elected;
- The Healthplan must receive proper payment of premiums;
- Continuation coverage for the Member terminates automatically on the earlier of:
  1. the date Member reaches age sixty-five (65);
  2. the date Member is covered under any group health plan that is not provided by Group, regardless of whether that coverage is less valuable;
  3. the date Member becomes eligible for Medicare;
  4. the date Group terminates this Agreement and ceases to provide coverage for any active employees; or
  5. for the Subscriber's spouse, five (5) years from the date COBRA or Cal-COBRA benefits were otherwise scheduled to expire for the spouse.

Continuation Coverage under California Law (Knox-Keene)

Continuation of Coverage for Totally Disabled Members

In the event this Agreement is terminated by Group or Healthplan, the Healthplan shall provide an extension of benefits to a Member who becomes totally disabled while enrolled under the Agreement and who continues to be totally disabled at the termination date of the Agreement, provided that the Member meets all of the following conditions:

1. The Member meets all eligibility requirements to receive services under this Agreement on the termination date of the Agreement and continues to meet those eligibility requirements during any extension of benefits period.
2. The Member resides in the Service Area of Healthplan on the termination date of the Agreement and continues to reside in the Service Area of Healthplan during any extension of benefits period.
3. For purposes of this benefit, a Member is considered totally disabled if, as a result of injury or illness, he or she is unable to engage in any employment or occupation for which he or she is or may reasonably become qualified by reason of education, training or experience, and who is not, in fact, engaged in any employment or occupation for wage or profit. If Member is a dependent or retired employee, Member is considered totally disabled if, he or she is unable to engage in substantially all of the normal activities of a person in good health of like age and sex because of injury or illness.
4. The services provided under this benefit are limited to covered services relating to the condition causing total disability and are subject to all terms, conditions, limitations and exclusions in the Agreement. Services and benefits shall be provided only when written certification of the disability and the cause

thereof has been furnished to the Healthplan Medical Director. Proof of continuation of the total disability must be furnished to the Healthplan Medical Director not less frequently than at sixty (60) day intervals during the period that the services and benefits are available. Healthplan shall require its contracting providers to certify ongoing total disability.

5. The Member's Extension of Benefits will cease upon the earliest of the following events:
   (a) twelve (12) months from the termination date of the Agreement; or
   (b) the Member is no longer totally disabled; or
   (c) the Member becomes eligible for coverage for the disabling condition under another health care benefits arrangement, including, but not limited to, an insurance policy, health plan contract, employee welfare benefit plan, or state or federal health benefit program (e.g. Medicare or Medicaid).

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Your Rights Under HIPAA Upon Termination Of This Group Agreement

HIPAA is the acronym for the federal law known as the Health Insurance Portability and Accountability Act of 1996. HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. California state law provides similar and additional protections.

If you lose your group health insurance coverage and meet certain important criteria, you are entitled to purchase coverage under an individual contract from any health plan that sells health insurance coverage to individuals. Significant protections come with the HIPAA individual contract: no pre-existing condition exclusions, guaranteed renewal at the option of the enrollee so long as the Plan offers coverage in the individual market and the enrollee pays the premiums, and limitations on the amount of the premium charged by the health plan.

Every health plan that sells health care coverage contracts to individuals must fairly and affirmatively offer, market, and sell HIPAA individual contracts to all Federally Eligible Defined Individuals. The plan may not reject an application from a Federally Eligible Defined Individual for a HIPAA individual contract if:

1. The Federally Eligible Defined Individual agrees to make the required premium payments;
2. The Federally Eligible Defined Individual, and his or her dependents to be covered by the plan contract, work or reside in the service area in which the plan operates.

You are a Federally Eligible Defined Individual if, as of the date you apply for coverage:

1. You have 18 or more months of creditable coverage without a break of 63 days or more between any of the periods of creditable coverage or since the most recent coverage has been terminated;
2. Your most recent prior creditable coverage was under a group, government or church plan. (COBRA and Cal-COBRA are considered employer group coverage);
3. You were not terminated from your most recent creditable coverage due to nonpayment of premiums or fraud;
4. You are not eligible for coverage under a group health plan, Medicare, or Medi-Cal (Medicaid);
5. You have no other health insurance coverage; and
6. You have elected and exhausted fully any continuation coverage you were offered under COBRA or Cal-COBRA.

There are important terms you need to understand, important factors you need to consider, and important choices you need to make in a very short time frame regarding the options available to you following termination of your group health care coverage. For example, if you are offered, but do not elect and exhaust COBRA or CAL-COBRA continuation coverage, you are not eligible for guaranteed issuance of a HIPAA individual contract. HIPAA coverage is also not available to you if you were eligible for Senior COBRA (Continuation after COBRA or Cal-COBRA under California Law) prior to January 1, 2005.

You should read carefully all of the information set forth in this section. Additional information is available

by calling us at the toll-free telephone number on your Cigna HealthCare identification card.

If you believe your HIPAA rights have been violated, you should contact the Department of Managed Health Care at 1-888-HMO-2219 or visit the Department's website at www.dmhc.ca.gov.

Continuation of Coverage Under FMLA

If the Group is subject to the requirements of the federal law known as the Family and Medical Leave Act of 1993, as amended (FMLA), 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.

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.

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

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 Dependents 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 Agreement.

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.

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.

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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 us for details regarding any such arrangements.

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.

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.

Compliance with Applicable Law

Healthplan is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 of Division 2 of the California Health and Safety Code) and the regulations promulgated thereunder (Title 28 of the California Code of Regulations), as amended from time to time, and any provisions required to be incorporated in this Agreement by either of the above shall bind Healthplan, whether or not provided for in this Agreement.

Confidentiality

Healthplan shall preserve the confidentiality of your health and medical records consistent with the requirements of applicable state and federal law.

A STATEMENT DESCRIBING THE HEALTHPLAN'S POLICIES AND PROCEDURES FOR PREVERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

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 this 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.

Health Care Fraud Reporting

Health care fraud impacts both the cost and quality of medical coverage, increases the cost of doing business and creates a loss of public confidence. Health care fraud is an intentional deception or misrepresentation that a Member, a Participating Provider, a Healthplan employee or some other entity or party makes, knowing that the misrepresentation could result in some unauthorized benefit to the Member, Participating Provider, a Healthplan employee, or to some other entity or party.

The most common kind of fraud involves a false statement, misrepresentation or deliberate omission that is critical to the determination of benefits payable. Fraudulent activities are criminal.

The Healthplan has as its continuing goal the prevention and detection of health care fraud and has established an anti-fraud program to help prevent fraud. If a Member has reason to suspect another Member, a Participating Provider, a Healthplan employee or some other entity or party of perpetrating health care fraud, the Member should call the Healthplan's anti-fraud hotline at 1.800.667.7145.

Liability of Member for Certain Charges

By statute, every contract between the Healthplan and a contracted provider shall provide that in the event the Healthplan fails to pay a Healthplan contracted provider, the Member will not be liable to the provider for any sums owed by the Healthplan.

However, in the event the Healthplan fails to pay a non-contracted provider, the Member may be liable to the non-contracted provider for the cost of services.

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 the 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 Line℠ and Cigna LIFESOURCE 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.

Termination of Provider Contracts

Healthplan shall provide written notice within a reasonable time to Group of any termination or breach of contract by, or inability to perform of, any Participating Provider if Group may be materially and adversely affected thereby. In the event that a contract between Healthplan and any Participating Provider is terminated while a Member is under the care of such Participating Provider, Healthplan shall retain financial responsibility for such care, in excess of any applicable Copayments. Such responsibility shall continue until the services being rendered are completed, or until Healthplan makes reasonable and medically appropriate provision for the assumption of such services by another Participating Provider, whichever occurs first.

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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.

(GSA) Federal.1 10/09

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.

(GSA) Federal.2 4/09

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.