



CIGNA HealthCare

MHMRA of Harris County

**CIGNA HealthCare of  
Texas, Inc.  
HMO**

FOR MORE INFORMATION OR TO MAKE A COMPLAINT, CALL THE NUMBER ON YOUR ID CARD

CIGNA HealthCare of Texas, Inc.  
6600 East Campus Circle Drive, Suite 400  
Irving, TX 75063

**THIS GROUP SERVICE AGREEMENT CONTAINS  
AN ARBITRATION CLAUSE, WHICH  
ARBITRATION IS BINDING.**

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



CIGNA HealthCare

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## IMPORTANT NOTICE

To obtain information or make a complaint:

You may call CIGNA HealthCare of Texas, Inc.'s toll-free telephone number for information or to make a complaint at:

**1-800-CIGNA24**

You may also write to CIGNA HealthCare of Texas, Inc. at:  
6600 East Campus Circle Drive, Suite 400  
Irving, TX 75063

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

**1-800-252-3439**

You may write the Texas Department of Insurance:  
P.O. Box 149104  
Austin, TX 78714-9104  
FAX # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

### PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

### ATTACH THIS NOTICE TO YOUR CONTRACT:

This notice is for information only and does not become a part or condition of the attached document.

## AVISO IMPORTANTE

Para obtener información o para someter una queja:

Usted puede llamar a número de teléfono gratis de CIGNA Healthcare of Texas, Inc.'s para información o para someter una queja al:

**1-800-CIGNA24**

Usted también puede escribirle a CIGNA HealthCare of Texas, Inc. a:  
6600 East Campus Circle Drive, Suite 400  
Irving, TX 75063

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al:

**1-800-252-3439**

Puede escribir al Departamento de Seguros de Texas:  
P.O. Box 149104  
Austin, TX 78714-9104  
FAX # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

### DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o la compañía primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

### UNA ESTE AVISO A SU CONTRATO:

Este aviso es solo para propósito de información y no se convierte en parte o condición del documento adjunto.



## NOTICE OF GRANDFATHERED PLAN STATUS

This plan is being treated as a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the phone number or address provided in your plan documents, to your employer or plan sponsor or an explanation can be found on CIGNA's website at [http://www.cigna.com/sites/healthcare\\_reform/customer.html](http://www.cigna.com/sites/healthcare_reform/customer.html).

If your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If your plan is a nonfederal government plan or a church plan, you may also contact the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov).



## **PATIENT PROTECTION AND AFFORDABLE CARE ACT ENDORSEMENT**

**The group contract or certificate 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.

### **Definitions**

“**Essential health benefits**” means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

“**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).

### **Lifetime Dollar Limits**

Any lifetime limit on the aggregate dollar value of essential health benefits is deleted. Any lifetime limits on the dollar value of any essential health benefits are deleted.

### **Annual Dollar Limits**

Any annual limit on the aggregate dollar value of essential health benefits is deleted and the greater of the following is substituted in its place: 1) \$750,000; or 2) the amount shown in the group contract or certificate.

Any annual limits on the dollar value of essential health benefits are deleted.

### **Rescissions**

Your coverage may not be rescinded (retroactively terminated) 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.

### **Extension of Coverage to Dependents**

Dependent children are eligible for coverage up to the age of 26. Any restrictions in the definition of Dependent in your plan document which require a child to be unmarried, a student, financially dependent on the employee, etc. no longer apply. If the definition of Dependent in the plan document provides coverage for a child beyond age 26, the provision and all restrictions will continue to apply starting at age 26. Any provisions related to coverage of a handicapped child continue to apply starting at age 26.

### **Preexisting Condition Limitations**

Any Preexisting Condition Limitation provision described in the plan document does not apply to anyone who is under 19 years of age.



## *Thank you for choosing CIGNA.*

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

Your plan:

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

It's easy to get the information you need.

- **myCIGNA.com** offers a number of self-service features. You can review your plan information; find participating physicians, specialists, pharmacies and hospitals closest to home or work; view the status of your claims; order a new CIGNA ID card; or change your PCP.
- **Customer Service Representatives** are ready to answer your questions and help solve problems. Just call the toll-free number on your CIGNA HealthCare ID card. Get information you need about your health care plan, including information about services that are covered, services that are not covered and any costs that you will be responsible for paying.
- **Your CIGNA ID card** lists the toll-free Customer Service phone number, your PCP's name and phone number, and payment information. Show your CIGNA ID card before you receive care.

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



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## **GROUP SERVICE AGREEMENT**

THIS GROUP SERVICE AGREEMENT  
CONTAINS AN ARBITRATION CLAUSE,  
WHICH ARBITRATION IS BINDING.



# I. Definitions of Terms Used In this Group Service Agreement

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

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

### Agreement

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

### Anniversary Date of Agreement

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

### Contract Year

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

### Copayment

The amount shown in the schedule of Copayments that you pay for certain covered Services and Supplies. The Copayment may be a fixed dollar amount or a percentage of the Participating Provider's negotiated charge.

### Custodial Services

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

Custodial Services include but are not limited to:

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

### Days

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

### Dependent

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

### Emergency Services

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

### Enrollment Application

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

### 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.

### Grace Period

The thirty-one (31) day period after the first day of the month during which the Prepayment Fees may be paid without loss of coverage under the Agreement.

### Group

The employer, labor union, trust, association, partnership, government entity, or other organization



# I. Definitions of Terms Used In this Group Service Agreement

listed on the Face Sheet to this Agreement which enters into this Agreement and acts on behalf of Subscribers and Dependents who are enrolled as Members in the Healthplan.

## Healthplan

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

## Healthplan Medical Director

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

## Limited Network

A network or association of health professionals who work together to provide a full range of health care services. If the Primary Care Physician is selected from a Limited Network, then all care, including specialty and hospital, will be provided by or arranged for within the network to which the Primary Care Physician belongs. Limited Networks may be delegated Utilization Management, Credentialing and Claims Processing functions.

## Medical Services

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

## Medically Necessary/Medical Necessity

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

- required to diagnose or treat an illness, injury, disease or its symptoms; and
- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration; and
- not primarily for the convenience of the patient, Physician, or other health care provider; and

- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Healthplan Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining the least intensive setting.

## Member

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

## Membership Unit

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

## Open Enrollment Period

The period of time established by the Healthplan and the Group as the time when Subscribers and their Dependents may enroll for coverage. The Open Enrollment Period occurs at least once every Contract Year and will last for at least one full calendar month of thirty-one (31) days.

## Other Participating Health Care Facility

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

## Other Participating Health Professional

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



# I. Definitions of Terms Used In this Group Service Agreement

## Participating Hospital

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

## Participating Physician

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

## Participating Provider

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

## Physician

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

## Prepayment Fee

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

## Primary Care Physician (PCP)

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

## Primary Plan

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

## Prior Authorization

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

## Qualified Medical Child Support Order

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

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

## Referral

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

## 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.

## Service Area

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



# I. Definitions of Terms Used In this Group Service Agreement

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## **Spouse**

The individual of the opposite sex with whom the Subscriber has entered into a marriage relationship, which would be considered valid under the Texas Family Code.

## **Subscriber**

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

## **Total Copayment Maximums**

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

## **Urgent Care**

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

## **We/Us/Our**

CIGNA HealthCare of Texas, Inc.

## **You/Your**

The Subscriber and/or any of his Dependents.

GSA-DEF(01) TX-E  
1/07



## II. Enrollment and Effective Date of Coverage

### Section II. Enrollment and Effective Date of Coverage

#### Who Can Enroll as a Member

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

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

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

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

1. be the Subscriber's Spouse, and you must live, reside or work in the Service Area; or
2. be the natural child, step-child, or adopted child of the Subscriber, or the child for whom the Subscriber is the legal guardian, or the child legally who is the subject of a lawsuit for adoption by the Subscriber, if the Subscriber has the legal responsibility for the health of the child, or the child supported pursuant to a court order imposed on the Subscriber (including a qualified medical child support order) or a grandchild of the Subscriber who is also a dependent of the Subscriber for federal income tax purposes, at the time application for coverage is made, provided that the child:
  - a. is unmarried and legally dependent upon the Subscriber for support;
  - b. resides in the Service Area (unless the child is a full-time registered student outside the Service Area or is covered under a Qualified Child Medical Support Order) or lives with the Subscriber who lives outside the Service Area (but works within the Service Area) and

- i. has not yet reached age twenty-five (25); or
- ii. the child is twenty-five (25) or older and incapable of self-sustaining support because of mental retardation or a physical handicap which existed prior to attaining twenty-five (25) years of age. You must submit proof of the child's condition and dependence to us within thirty-one (31) days after the date the child ceases to qualify as a Dependent under subsection (i) above. We may, from time to time, require proof of the continuation of the child's condition and dependence. We may require such proof only once a year.

GSA-ENRL(01) TX-C  
7/04

#### 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.



## II. Enrollment and Effective Date of Coverage

2. If you are a Subscriber who is enrolled as a Member, you may enroll a newborn child prior to the birth of the child or within thirty-one (31) days after the child's birth. Newborn children of the Subscriber are covered for the first thirty-one (31) days after birth. To enroll a newborn child, you must submit an Enrollment Application, together with any additional fees due, to the Group. If so enrolled, the effective date of coverage for your newborn child will be the date of his birth.

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

3. If you are a Subscriber who is enrolled as a Member, you may enroll an adopted child or child for whom you have been granted legal guardianship within thirty-one (31) days of the date that you become a party in a suit for adoption of the child if you have legal responsibility for the health of the child or within thirty-one (31) days of the date you are granted legal guardianship of the child. To enroll an adopted child or 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 for your child will be the date that you became a party in a suit for adoption of the child or the date of court ordered legal guardianship of the child.

If you do not enroll an adopted child or 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. Full and Accurate Completion of Enrollment Application

Each Subscriber must fully and accurately complete the Enrollment Application. You represent that all information shown in such applications shall be true, correct and complete to the best of your knowledge and belief. All right and benefits hereunder are subject to the condition that such information shall be true,

correct and complete. False, incomplete or misrepresented information provided in any Enrollment Application may, in the Healthplan's sole discretion, cause the coverage of the Subscriber and/or his Dependents to be null and void from its inception. A statement will not be used in a contest to void, cancel or non-renew your coverage or to reduce benefits unless:

1. the statement is in a copy of the Enrollment Application; and
2. a signed copy of the Enrollment Application is or has been furnished to you or your representative.

Coverage will only be contested because of fraud or intentional misrepresentation of a material fact on an Enrollment Application.

### D. Hospitalization on the Effective Date of Coverage

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

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

### E. 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 "Termination For Cause" provision of "Section VII. Termination of Your Coverage" and



CIGNA HealthCare

## II. Enrollment and Effective Date of Coverage

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2. not have any unpaid financial obligations to the Healthplan or any other CIGNA HealthCare Healthplan.

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### 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. All Members will be provided with a Provider Directory at enrollment without charge. The Provider Directory includes a map and Zip Code listing of the Service Area and a list of Participating Providers. If you would like another Provider Directory, 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." The decision regarding whether or not to utilize a hospitalist is between you and your PCP. Usage of a hospitalist is not required under your plan.

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

When you enroll as a Member, you choose a Primary Care Physician (PCP). Each covered Member of your family also chooses a PCP. 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 but not more than once in any calendar month. We reserve the right to determine the number of times during a Contract Year that you will be allowed to change your PCP. You will not be limited to any less than four (4) times in any Contract Year. 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 and facilities from which you may receive services. Your choice of a



### III. Agreement Provisions

specialist may be limited to specialists in your PCP's medical group or network, including a Limited Network. Therefore, you may not have access to every specialist or Participating Provider in your Service Area. Before you select a PCP, you should check to see if that PCP is associated with the specialist or facility you prefer to use. If the Referral is not possible, you should ask the specialist or facility about which PCPs can make Referrals to them, and then verify the information with the PCP before making your selection.

#### 9. Specialists as Primary Care Physicians

If you have a chronic disabling or life-threatening illness, you may apply to the Healthplan Medical Director to request that your treating specialist become the coordinator of all of our care. Your specialist must agree to:

- become the coordinator of all of your care;
- meet and accept all of our requirements and payment schedules for Primary Care Physicians; and
- sign your request

If you are not satisfied with the Healthplan Medical Director's response to your request, you may appeal the response as provided in "subsection C. When You Have a Complaint or an Appeal of an Adverse Determination."

#### 10. Services by Non-Participating Providers

If you need covered services and our Participating Provider network does not contain a Participating Provider with the specialty necessary to treat you, your Participating Physician may request a referral to a non-Participating Provider who will be reimbursed at the prevailing Participating Provider rate or at a rate agreed upon between us and the non-Participating Provider. The Healthplan Medical Director has the right to refer you to a non-Participating Provider of his choice or to deny the request for referral if he feels that the services can be adequately provided by a Participating Provider. The Healthplan

Medical Director may not make any denials unless a provider of the same or similar specialty has reviewed the request for referral.

#### 11. Referrals to Specialists

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

##### Exceptions to the Referral process:

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

You do not need a Referral from your PCP for Emergency Services as defined in the "Section IV. Covered Services and Supplies." In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral from your PCP for Emergency Services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care. 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 emergency, you should seek immediate medical attention and then as soon as possible thereafter you need to call your PCP for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorization for care or hospitalization.

In an Urgent Care situation a Referral is not required but you should, whenever possible,



## III. Agreement Provisions

contact your PCP for direction prior to receiving services.

### 12. Continuity of Treatment

We will give you reasonable written notice of the impending termination of a Participating Provider from whom you are currently receiving treatment.

If you are receiving treatment from a Participating Provider at the time the Participating Provider agreement is terminated, for reasons other than medical incompetence or professional misconduct, you may be eligible for continued care with that provider. To be eligible for this continued care you must be receiving treatment in accordance with the dictates of medical prudence for (a) a disability; (b) an acute condition; (c) a life threatening illness or (d) for pregnancy past the twenty fourth (24th) week, and your treating provider reasonably believes that discontinuing your care with him may cause you harm. Care may be continued with the provider as follows: (a) for up to nine (9) months if you have been diagnosed with a terminal illness; (b) through delivery of the child, including immediate postpartum care and a follow up checkup within the six (6) week period after delivery if you are past the twenty-fourth (24th) week of pregnancy; or (c) for up to ninety (90) days after the effective date of the provider's termination. Your provider must identify your special circumstance to the Healthplan Medical Director and request that you continue under his care. Your provider must agree not to seek payments from you except for Copayments. The Healthplan Medical Director may deny this request if he determines that your treatment may be transferred to another provider without causing you harm or if he determines that the request is not Medically Necessary.

### 13. Provider Compensation

We compensate our Participating Providers in ways that are intended to emphasize preventive care, promote quality of care, and assure the most appropriate use of Medical Services. You can discuss with your

provider how he is compensated by us. The methods we use to compensate Participating Providers are:

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

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

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

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

We may also work with third parties who administer payments to Participating Providers. Under these arrangements, we pay the third party a fixed monthly amount for these services. Providers are compensated by the third party for services provided to Healthplan participants from the fixed amount. The compensation varies based on overall utilization.

Salary – Physicians and other providers who are employed to work in our medical facilities are paid a salary. The compensation is based on a dollar amount, decided in advance each year, that is guaranteed regardless of the services



### III. Agreement Provisions

provided. Physicians are eligible for any annual bonus based on quality of care, quality of service and appropriate use of Medical Services.

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

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

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

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#### B. Member’s Rights, 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.
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.



### III. Agreement Provisions

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

**You represent that:**

1. The information provided to us and the Group in the Enrollment Application is complete and accurate.
2. By enrolling in the Healthplan, you accept and agree to all terms and conditions of this Agreement.
3. By presenting your CIGNA HealthCare ID card and receiving treatment and services from our Participating Providers, you

authorize the following to the extent allowed by law:

- a. any provider to provide us with information and copies of any records related to your condition and treatment;
- b. any person or entity having confidential information to provide any such confidential information upon request to us, any Participating Provider, and any other provider or entity performing a service, for the purpose of administration of the plan, the performance of any Healthplan program or operations, or assessing or facilitating quality and accessibility of health care Services and Supplies;
- c. us to disclose confidential information to any persons, company or entity to the extent we determine that such disclosure is necessary or appropriate for the administration of the plan, the performance of the Healthplan programs or operations, assessing or facilitating quality and accessibility of healthcare Services and Supplies, or reporting to third parties involved in plan administration; and
- d. that payment be made under Part B of Medicare to us for medical and other services furnished to you for which we pay or have paid, if applicable.

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

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

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



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### C. When You Have A Complaint or an Appeal of an Adverse Determination

(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're here to listen and help. We want you to be completely satisfied with the Healthplan and the care you receive. That's why we've established a process for addressing your concerns and solving your problems. If you are dissatisfied about any aspect of the Healthplan's operation, you can call the toll-free number on our CIGNA HealthCare ID card and explain your situation to one of our Member Services representatives. You can also express that concern by walk-in interview, arranged appointment, or in writing at the following:

CIGNA HealthCare of Texas, Inc.  
National Appeals Unit  
P.O. Box 188011  
Chattanooga, TN 37422

Healthplan Toll-Free Number appears on your CIGNA HealthCare ID card

The process which we will use to address your concern depends on the nature of your issue. If you are dissatisfied about any aspect of the Healthplan's operation other than an issue related to Medical Necessity, your concern is considered to be a Complaint and would follow the "Complaints and Complaint Appeals Process". For issues related to Medical Necessity, your concern is considered to be an Adverse Determination and would follow the "Adverse Determination Appeal Process".

#### Complaints and Complaint Appeals Process

##### Complaints

Complaints include dissatisfaction with plan administration procedures, denial, reduction, or termination of a service for reasons not related to Medical Necessity, disenrollment decisions or the way a service is provided. A Complaint does not include: (a) a misunderstanding or problem of misinformation which we can resolve by clearing up the misunderstanding or by supplying the correct information to your

satisfaction; or (b) you or your provider's dissatisfaction or disagreement with an Adverse Determination.

You may notify us of your Complaint orally or in writing. We will send you a letter acknowledging the date on which we received your Complaint no later than the 5<sup>th</sup> business day after we receive your Complaint. If you notify us of your Complaint orally, we will send you a one-page Complaint form that you must return to us for prompt resolution of the Complaint.

We'll get back to you with a decision in writing, as soon as possible. If the Complaint relates to a pre-service or concurrent care coverage determination which requires prior authorization under the plan and your Complaint is filed before you receive the service, we will respond with a decision within fifteen (15) calendar days after we receive your Complaint. For all other issues, we will respond with a decision within thirty (30) calendar days after we receive your Complaint.

You may request that the Complaint Process be expedited, if: (a) the time frames under the Complaint Process would seriously jeopardize your life, health, or ability to regain maximum functionality, or, in the opinion of your treating physician would cause you severe pain, which cannot be managed without the requested services; or (b) your Complaint involves non-authorization of an admission or a continuing inpatient stay. The Healthplan Medical Director, in consultation with your treating physician, will decide if it is necessary to expedite the Complaint Process. When the Complaint Process is expedited, we will respond orally with a decision within one (1) business day or sooner from the date we receive your request. We will follow up in writing within two (2) calendar days.

If you are not satisfied with the Complaint resolution decision, you can start the Complaint Appeal Process.

##### Complaint Appeals

If we do not resolve your Complaint to your satisfaction, you have the right to appeal our decision to our Complaint Appeal Panel. You may appeal by appearing in person,



## III. Agreement Provisions

telephonically, or by other technological means before the Complaint Appeal Panel or by presenting a written appeal to the Complaint Appeal Panel. The Complaint Appeal Panel will meet in the Service Area where you normally receive health care services, unless you agree to another location. When you appeal your Complaint:

- (1) We will send an acknowledgment letter to you within five (5) business days after the date we receive your request for a Complaint Appeal.
- (2) We will appoint individuals to form a Complaint Appeal Panel. The Complaint Appeal Panel will advise us on the resolution of the Complaint Appeal. The Complaint Appeal panel will include an equal number of: (a) our staff; (b) physicians or other providers; and (c) enrollees. No members of the Complaint Appeal Panel will have been involved with prior decisions related to your issue.
- (3) We will send you copies of any documentation which we plan to present to the Complaint Appeal Panel no later than the fifth (5<sup>th</sup>) business day before the Complaint Appeal Panel is scheduled to meet. We will also send you the specialization of any physician or providers with whom we consulted during our investigation of your Complaint and the names and affiliations of each of our staff members who will serve on the Complaint Appeal Panel.
- (4) We will notify you of the Complaint Appeal Panel's decision no later than the fifteenth (15<sup>th</sup>) calendar day after we receive your Complaint Appeal request if the issue relates to a pre-service or concurrent coverage determination which requires prior authorization under the plan and you filed your Complaint Appeal before the service is rendered. We will respond no later than the thirtieth (30<sup>th</sup>) calendar day after we receive your Complaint Appeal request for any other issue.

You may request that the Complaint Appeal Process be expedited if: (a) the time frames under the Complaint Appeal Process would seriously jeopardize your life, health, or ability to regain maximum functionality, or, in the opinion of your treating physician, would cause you severe pain, which cannot be managed without the requested services; or (b) your Complaint Appeal involves non-authorization of an admission or a continuing inpatient stay. The Healthplan Medical Director, in consultation with your treating physician, will decide if the Complaint Appeal Process should be expedited. When a Complaint Appeal is expedited, we will respond orally with a decision within one (1) business day or sooner from the date we receive your Complaint Appeal request. We will follow up in writing within two (2) calendar days.

### **Adverse Determination Appeals and Independent Review of Adverse Determinations**

#### **Adverse Determination Appeals**

An Adverse Determination is a decision made by the Healthplan that the health care services furnished or proposed to be furnished to you are not Medically Necessary or appropriate. An Adverse Determination also includes a denial by the Healthplan of a request to cover a specific prescription drug prescribed by your physician.

If you do not agree with the Adverse Determination, you may appeal the Adverse Determination orally or in writing. We will acknowledge our receipt of your Adverse Determination Appeal in writing within five (5) business days after we receive your Adverse Determination Appeal. If you notify us orally of your Adverse Determination Appeal, we will send you a one-page Adverse Determination Appeal form that you must return to us for prompt resolution of the Adverse Determination Appeal.

Your Adverse Determination Appeal will be reviewed and the decision will be made by a health care professional who was not involved in the initial Adverse Determination and who is in the same or similar specialty that typically manages the medical or dental condition, procedure or treatment under review. We will respond in writing with a decision within thirty



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(30) calendar days after we receive the request for an Adverse Determination Appeal.

You may request that the Adverse Determination Appeal Process be expedited if: (a) the time frames under the Adverse Determination Appeal Process would seriously jeopardize your life, health, or ability to regain maximum functionality or, in the opinion of your treating physician, would cause you severe pain, which cannot be managed without the requested services; or (b) the Adverse Determination involves non-authorization of an admission or a continuing inpatient stay. The Healthplan Medical Director, in consultation with your treating physician, will decide if an expedited Adverse Determination Appeal is necessary. When an Adverse Determination Appeal is expedited, we will respond orally with a decision within one (1) business day or sooner from the date we receive your request. We will follow up in writing within two (2) calendar days.

#### **Independent Review Process for Adverse Determinations Appeals**

The Texas Department of Insurance oversees an Independent Review Process for Adverse Determination Appeals. If you are not fully satisfied with the Adverse Determination Appeal decision, you may request that your Adverse Determination Appeal be referred to an Independent Review Organization for review. You may request an Independent Review of an Adverse Determination without completing the Healthplan’s Adverse Determination Appeal Process if you feel your condition is life-threatening. Complaint Appeal decisions are not eligible for Independent Review.

The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates and the Independent Review Organization is completely separate from the Healthplan. A decision to use the Independent Review Process will not affect your rights to any other benefits under the plan. There is no charge to initiate the Independent Review Process. We will provide you and your treating physician with the necessary forms to request an Independent Review when we make an Adverse

Determination or when we make an Adverse Determination Appeal decision. If your condition is life threatening, you may contact us by telephone to initiate the Independent Review Process. We will abide by the decision of the Independent Review Organization.

GSA-PROV(03) TX-D  
7/04

#### **Right to Contact the State of Texas**

You have the right to contact the Texas Department of Insurance (TDI) for assistance with your Complaint, Complaint Appeal or Adverse Determination Appeal at any time. You may also contact TDI if you do not believe we have complied with Texas regulations regarding the handling of Complaints, Complaint Appeals or Adverse Determination Appeals. TDI may be contacted at the following address and telephone number:

Texas Department of Insurance  
333 Guadalupe Street  
P.O. Box 149104  
Austin, Texas 78714-9104

800-252-3439 (toll-free telephone number)

512-475-1771 (facsimile number)

[www.TDI.state.tx.us](http://www.TDI.state.tx.us) (e-mail)

#### **Contents of Complaint, Complaint Appeal and Adverse Determination Appeal Notices**

Every notice of a Complaint, Complaint Appeal and Adverse Determination Appeal decision will be provided in writing or electronically and will include: (1) the specific medical or contractual reason or reasons for the denial decision; (2) the specialty of any physician or health care provider consulted in making the denial decision; (3) reference to the specific plan provisions on which the decision is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other Relevant Information, as defined; (5) a statement describing any voluntary appeal procedures offered by the Plan and the claimant’s right to bring an action under ERISA section 502(a) if the plan is governed by ERISA; (6) a copy of any internal rule, guideline,



### III. Agreement Provisions

protocol or other similar criterion that was relied upon in making the Complaint, Complaint Appeal or Adverse Determination Appeal decision, including 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) instructions for filing complaints with the Texas Department of Insurance.

If your plan is governed by ERISA, you also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the Complaint, Complaint Appeal or Adverse Determination Appeal decision. 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.

In most instances, you may not initiate a legal action against the Healthplan until you have completed the Complaint Appeal or Adverse Determination Appeal process, as appropriate. If your Complaint or your Adverse Determination Appeal is expedited, you do not need to complete the Complaint or Adverse Determination Appeal process prior to bringing legal action.

#### 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.

GSA-PROV(04) TX-C  
7/04

#### Arbitration

Any controversy between the Healthplan and the Group, or a Member (including any legal representative acting on behalf of a Member), arising out of or in connection with this Agreement may be submitted to arbitration upon written agreement between both parties. Such arbitration shall be governed by the provisions of Texas Arbitration Act, Texas Civil Practice and Remedies Code Section 171.001 et. seq. For cases related to Adverse Determinations, arbitration will not be imposed prior to a review by an Independent Review Organization (IRO), as provided for under Texas law.

GSA-PROV(05) TX-B  
5/05

#### D. How to File a Claim and How Claims Will be Paid

If you receive care from non-Participating Providers, you must submit a claim to us no later than sixty (60) days after the first service is provided. The claim shall contain an itemized statement of treatment, expenses and diagnosis. The claim should be sent to the address on the back of your Member Identification Card. 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.

No later than fifteen (15) days after we receive the claim, we will:

- 1) Acknowledge receipt of the claim;
- 2) Begin investigating the claim; and
- 3) Request any additional information, statements or forms deemed necessary. Additional requests may be made during the course of the investigation.



## III. Agreement Provisions

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No later than fifteen (15) days after we receive all requested items and information, you will be notified of the acceptance or rejection of the claim or that additional time is needed. We will state the reason(s) if the claim is rejected or if additional time is needed. The claim will be accepted or rejected no later than forty-five (45) days after the date of notification of the additional time requirements.

The claim will be paid no later than five (5) days after notification of acceptance of the claim.

GSA-PROV(06)TX  
10/05



## IV. Covered Services and Supplies

### 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 your PCP has given you a Referral, by another Participating Provider. However, “Emergency Services” do not require a Referral from your PCP and do not have to be provided by Participating Providers. Also, you do not need a Referral from your PCP for “Obstetrical and Gynecological Services,” 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, outpatient facility services, advanced radiological imaging, non-emergency ambulance, and Transplant Services.

#### Physician Services

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

#### Inpatient Hospital Services

Inpatient hospital services for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in an Other Participating Health Care Facility. Inpatient hospital services include semi-private room and board; care and services in an intensive care unit; drugs,

medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; laboratory and radiology services and other diagnostic and therapeutic services; anesthesia and associated services; inhalation therapy; radiation therapy; and other services which are customarily provided in acute care hospitals. Inpatient Hospital Services for the treatment of breast cancer will be covered for a minimum of : (1) 48 hours following a mastectomy; and (2) 24 hours following a lymph node dissection.

#### Outpatient Facility Services

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

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#### Emergency Services and Urgent Care

**Emergency Services Both In and Out of the Service Area.** In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral 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. 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 Services are defined as the medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service,



## IV. Covered Services and Supplies

which are required to treat a sudden unexpected onset of a bodily injury or a serious illness which could reasonably be expected by a prudent layperson to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, serious disfigurement or, in the case of a pregnancy, serious jeopardy to the health of the fetus in the absence of immediate medical attention. Examples of emergency situations include 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, burns, cuts, and broken bones.

Emergency Services include any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists and the necessary emergency care services provided for the treatment and stabilization of an emergency medical condition.

**Urgent Care Inside the Service Area.** For Urgent Care inside the Service Area, you must take all reasonable steps to contact 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<sup>SM</sup> 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 typically provided in a setting such as a physician's or provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition or his or her health. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or are scheduled to receive services. Such non-Urgent 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, follow-up, or post-stabilization treatment, whether in or out of the Service Area, is not covered unless it is provided or arranged for by your PCP or upon Prior Authorization of the Healthplan Medical Director. Requests made by your treating Physician for post-stabilization treatment will be approved or denied within the time appropriate for your condition and circumstances, but in no situation will the approval or denial be made later than one hour after the request for post-stabilization care has been received by the Healthplan Medical Director.

**Notification, Proof of a Claim, and Payment.** Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and authorization by the Healthplan Medical Director. Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than within forty-eight (48) hours of admission. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided that notification is given to us as soon as reasonably possible. If you receive Emergency Services or Urgent Care from non-Participating Providers, you must submit a claim to us no later than sixty (60) days after the first service is provided. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided you submit the claim and the itemized statement to us as soon as reasonably possible.

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### Acquired Brain Injuries

Necessary services as a result of and relating to an "acquired brain injury" including: cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community re-integration services.



## IV. Covered Services and Supplies

### Ambulance Service

Ambulance services to the nearest appropriate provider or facility.

### Anesthesia for Dental Procedures

Anesthesia services related to dental procedures in order to safely and effectively perform the dental treatment if you have a serious medical, physical or mental condition.

### Bone Mass Measurement, Hearing Screenings for Newborns and Prostate Cancer Test (PSA)

Bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass is covered for Members who meet the following criteria:

- A) post-menopausal women who are not receiving estrogen replacement therapy;
- B) a Member with:
  - 1) vertebral abnormalities;
  - 2) primary hyperparathyroidism
  - 3) a history of bone fractures; or
- C) a Member who is:
  - 1) receiving long-term glucocorticoid therapy; or
  - 2) being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

One Screening test for hearing loss for newborn children age birth to thirty (30) days old and necessary diagnostic follow-up care related to the screening test for newborn children age birth through twenty-four (24) months old.

Annual physical examination for the detection of prostate cancer and a prostate-specific antigen test (PSA) for men who are either:

- at least 50 years old and asymptomatic; or
- at least 40 years old with a family history of prostate cancer or another prostate cancer risk factor.

### Breast Reconstruction and Breast Prostheses

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

- surgical services for reconstruction of the breast on which surgery was performed;
- surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
- post-operative breast prostheses; and
- mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs.

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

### Clinical Trials

Routine Patient Services associated with cancer clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:

- The cancer clinical trial is listed on the National Institutes of Health web site [www.clinicaltrials.gov](http://www.clinicaltrials.gov) as being sponsored by the federal government.
- The trial investigates a treatment for terminal cancer and: 1) the member has failed standard therapies for the disease; or 2) cannot tolerate standard therapies for the disease; or 3) no effective non-experimental treatment for the disease exists.
- The Member meets all inclusion criteria for the clinical trial and is not treated “off-protocol.”
- The trial is approved by the Institutional Review Board of the institution administering the treatment.
- Coverage will not be extended to clinical trials conducted at non-participating facilities if a member is eligible to participate in a covered clinical trial from a Participating Provider.

Routine Patient Services do not include, and reimbursement will not be provided for:

- The investigational service or supply itself.



## IV. Covered Services and Supplies

- Services or supplies listed herein as Exclusions or Limitations.
- Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs).
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

### Cervical Cancer Screening

Coverage includes the normal expenses incurred in conducting a medically recognized screening examination for the detection of cervical cancer for female enrollees 18 years of age or older on an annual basis. At a minimum these benefits include:

- A. A conventional Pap smear screening; or
- B. A screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

### Colorectal Cancer Screening

Coverage includes the normal expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer for enrollees 50 years of age or older, and at normal risk for developing colon cancer. These benefits include an annual fecal occult blood test and either a flexible sigmoidoscopy performed every five years or a colonoscopy performed every ten years.

### Contraceptive Coverage

If your Plan provides prescription drug coverage, all FDA-approved contraceptive drugs and devices, including outpatient contraceptive services, shall be covered in accordance with formulary guidelines. Coverage is not provided for abortifacients (“morning-after pill”) or any other drug or device that terminates pregnancy.

Oral contraceptives shall be covered under the prescription drug rider, and standard formulary Copayments will apply. Injectable contraceptives and contraceptive devices that require insertion or

implantation by your Physician, shall be covered under the “Covered Services and Supplies” section of this Agreement, and standard medical Copayments shall apply.

### Craniofacial Abnormalities Services

Reconstructive surgery of craniofacial abnormalities for children under eighteen (18) years of age. The purpose of the surgery is to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused congenital defects, developmental deformities, trauma, tumors, infections or disease.

### Diabetic Services and Supplies

Diabetic services and treatment consisting of diabetes equipment, supplies and self-management training programs as prescribed and rendered by a Participating Provider for insulin dependent or non-insulin dependent diabetes.

Diabetic equipment means: (a) blood glucose monitors, including monitors designed to be used by blind individuals; (b) insulin pumps and associated appurtenances; (c) insulin infusion devices; and (d) podiatric appliances for the prevention of complications associated with diabetes.

Diabetic supplies means: (a) test strips for blood glucose monitors; (b) visual reading and urine test strips; (c) lancets and lancet devices; (d) insulin and insulin analogs, (e) injection aids; (f) syringes; (g) prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and (h) glucagons emergency kits.

Investigational and experimental drugs will not be covered.

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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 anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a Member's misuse are the Member's responsibility.



## IV. Covered Services and Supplies

Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the Healthplan Medical Director.

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

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

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### External Prosthetic Appliances and Devices

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

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

### Prostheses/Prosthetic Appliances and Devices

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

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

### Orthoses and orthotic devices

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

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



## IV. Covered Services and Supplies

- a. For Members with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
- b. When the foot orthosis is an integral part of a leg brace, and it is necessary for the proper functioning of the brace;
- c. When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of illness, injury, or congenital defect; and
- d. For Members with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot, and there is reasonable expectation of improvement.

The following are specifically excluded orthosis and orthotic devices:

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

### Braces

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

The following braces are specifically excluded:

- Copes scoliosis braces.

### Splints

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

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

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

Coverage for replacement is limited as follows:

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

The following are specifically excluded external prosthetic appliances and devices:

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

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### Family Planning Services (Contraception and Voluntary Sterilization)

Family planning services including: medical history; physical examination; related laboratory tests; medical supervision in accordance with generally accepted medical practice; other Medical Services; information and counseling on contraception; implanted/injected contraceptives; and, after appropriate counseling, Medical Services connected with surgical therapies (vasectomy or tubal ligation).



## IV. Covered Services and Supplies

### 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 Contract Year for both pre- and post-genetic testing.

### Home Health Services

Home health services when you:

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

Home health services are provided only if the Healthplan Medical Director has determined that the home is a medically appropriate setting.

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. 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.

### Hospice Services

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

Hospice care services do not include the following:

- services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house;
- services and supplies for curative or life-prolonging procedures;
- services and supplies for which any other benefits are payable under the Agreement;
- services and supplies that are primarily to aid you or your dependent in daily living;
- services and supplies for respite (custodial) care; and
- nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

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

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



## IV. Covered Services and Supplies

during the illness; and a program for persons who have a terminal illness and for the families of those persons.

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

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### Inpatient Services at Other Participating Health Care Facilities

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

### Internal Prosthetic/Medical Appliances

Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functional body parts are covered, including testicular implants following Medically Necessary surgical removal of the testicles. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

### Laboratory and Radiology Services

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

### Maternity Care Services

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

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

stay, one follow-up visit will be provided in the mother's home; the provider's office; a health care facility or some other appropriate location.

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### Chemical Dependency Services

**Chemical Dependency** is defined as the psychological or physical dependence on alcohol or controlled substances (including toxic inhalants) 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 chemical dependency.

### Chemical Dependency Services

Chemical dependency services when required for the diagnosis, treatment and rehabilitation of addiction to alcohol and/or controlled substances. These services will be provided under the same guidelines as other illnesses. 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. Inpatient chemical dependency benefits are exchangeable with partial hospitalization sessions when benefits are provided for not less than four (4) hours and not more than twelve (12) hours in any twenty-four (24) hour period. The benefit exchange will be two (2) partial hospitalization sessions are equal to one (1) day of inpatient care.

### Chemical Dependency 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 chemical dependency conditions. Chemical Dependency Residential Treatment services are exchanged with Inpatient Chemical Dependency services at a rate of two (2) days of Chemical Dependency Residential Treatment being equal to one (1) day of Inpatient Chemical Dependency Services.

Chemical Dependency Residential Treatment Center means an institution which (a) specializes



## IV. Covered Services and Supplies

in the treatment of psychological and social disturbances that are the result of substance abuse; (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 Chemical Dependency Residential Treatment Center when he is a registered bed patient in a Chemical Dependency Residential Treatment Center upon the recommendation of a Physician.

### Chemical Dependency Intensive Outpatient Therapy Program

A Chemical Dependency Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed chemical dependency 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.

Chemical Dependency Intensive Outpatient Therapy Program services are exchanged with Outpatient Chemical Dependency visits at a rate of one (1) visit of Chemical Dependency Intensive Outpatient Therapy being equal to one (1) visit of Outpatient Chemical Dependency Services.

### Excluded Chemical Dependency Services

The following are specifically excluded from chemical dependency 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 occupational problems; and
- Custodial care.

### Serious Mental Illness Services

Serious Mental Illness is defined as the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia;
- Paranoid and other psychotic disorder;
- Bipolar disorder (hypomanic, manic depressive and mixed);
- Major depressive disorders;
- Schizoaffective disorders (bipolar or depressive);
- Pervasive developmental disorders;
- Obsessive-compulsive disorder; and
- Depression childhood and adolescence.

Services of Participating Providers and Participating Hospitals for the treatment and evaluation of a Serious Mental Illness. Visits for the sole purpose of managing and adjusting medications used to treat Serious Mental Illness will not be counted toward outpatient limits.

### Serious Mental Illness Intensive Outpatient Therapy Program

A Serious Mental Illness 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.

Serious Mental Illness Intensive Outpatient Therapy Program services are exchanged with Outpatient Serious Mental Illness visits at a rate of one (1) visit of Serious Mental Illness Intensive Outpatient Therapy being equal to one (1) visit of Outpatient Serious Mental Illness Services.

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### Mental Health Services other than Serious Mental Illness

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



## IV. Covered Services and Supplies

### Inpatient Mental Health Services

Inpatient services that are provided by a Participating Hospital for the treatment and evaluation of mental health. In addition, such services may be provided in a crisis stabilization unit, psychiatric day treatment facility or a residential treatment facility for children and adolescents that qualifies as an Other Participating Health Care Facility. Two (2) days of treatment in a crisis stabilization unit, psychiatric day treatment facility or residential treatment facility for children and adolescents is equal to one (1) day of treatment as an inpatient in a Participating Hospital program.

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

### Outpatient Mental Health Services

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

### 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.

Mental Health Intensive Outpatient Therapy Program services are exchanged with Outpatient Mental Health visits at a rate of one (1) visit of Mental Health Intensive Outpatient Therapy being equal to one (1) visit of Outpatient Mental Health Services.

### Excluded Mental Health Services

The following are specifically excluded from mental health services:

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



## 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.

### Obstetrical and Gynecological Services

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

Please note that, in some cases, your PCP may belong to a Limited Network, which means the network that your PCP belongs to may limit your selection of Participating Providers from whom you may choose to access for obstetrical and gynecological services. You should make certain that your PCP's network includes the Specialists, particularly the OB/GYN providers and hospitals, that you prefer. You may elect to receive obstetrical and gynecological services from your Primary Care Physician.

### Transplant Services

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

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

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

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

### Transplant Travel Services

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

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

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

The following are specifically excluded travel expenses:

- Travel costs incurred due to travel within 60 miles of your home;



## IV. Covered Services and Supplies

- Laundry bills;
- Telephone bills;
- Alcohol or tobacco products; and
- Charges for transportation that exceed coach class rates.

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

### Oxygen

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

### Reconstructive Surgery

Reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement, which is accompanied by functional deficit (other than abnormalities of the jaw or related to TMJ disorder) provided that:

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

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

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Revised 7/04

### 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, TMJ disorder, 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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7/06

### Rehabilitative Therapy

Rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, cardiac rehabilitation and pulmonary rehabilitation therapy, provided that:

- The therapy is performed in the most medically appropriate setting; and
- The therapy meets or exceeds the treatment goals for the Member, in the opinion of the treating physician. For a person who is physically disabled, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

Chiropractic services are not covered under this rehabilitative therapy provision. These services include the management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

GSA-BEN(10).1 TX-C  
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### Telehealth and Telemedicine Medical Services

Telehealth and Telemedicine Medical Services are services provided for the diagnosis, consultation, treatment or transfer of medical data and medical education through the use of Advance Telecommunications Technology, other than by



## IV. Covered Services and Supplies

telephone or facsimile. Such Advanced Telecommunications Technology includes:

- compressed digital interactive video, audio or data transmission;
- clinical data transmission using computer imaging by way of still-image capture; and
- other technology that facilitates access to health care services or medical specialty expertise.

These benefits may not be subject to a greater deductible, copayment or coinsurance than for a comparable medical service provided through a face-to-face consultation.

A Telemedicine Medical Service is a health care service initiated by a Participating Physician or provided by an Other Participating Health Professional acting under Physician delegation and supervision for purposes of patient assessment by an Other Participating Health Professional; diagnosis or consultation by a Participating Physician; and treatment or the transfer of medical data that requires the use of Advanced Telecommunications Technology. A Telehealth Service means a health service, other than a Telemedicine Medical Service, delivered by an Other Participating Health Professional, which requires the use of Advanced Telecommunications Technology.

### Temporomandibular Joint Dysfunction

Diagnostic and treatment services, including surgery, panorex x-rays, lateral transcranial x-rays and/or tomogram and arthogram, for temporomandibular (jaw or craniomandibular) joint disorders when rendered by a Participating Provider or Participating Facility which are a result of:

- An accident;
- Trauma;
- A congenital defect;
- A developmental defect; and
- A pathology

Dental services are not covered in any situation.

### Vision and Hearing Screenings for Dependents

Vision and hearing screenings provided by your PCP, provided you are under the age of 18 years.

GSA-BEN(12) TX-A  
1/04



## V. Exclusions and Limitations

### Section V. Exclusions And Limitations

#### Exclusions

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

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

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

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

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

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

- The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies;" or
  - The subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of the "Section IV. Covered Services and Supplies."
8. Cosmetic surgery and therapy, except as specified in the "Breast Reconstruction and Breast Prostheses," "Craniofacial Abnormalities Services" and "Reconstructive Surgery" subsections of "Section IV. Covered Services and Supplies." Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
  9. The following services are excluded from coverage regardless of clinical indications:
    - Macromastia or Gynecomastia Surgeries;
    - Surgical treatment of varicose veins;
    - Abdominoplasty;
    - Panniculectomy;
    - Rhinoplasty;
    - Blepharoplasty;
    - Redundant skin surgery;
    - Removal of skin tags;
    - Acupressure;
    - Craniosacral/cranial therapy;
    - Dance therapy, movement therapy;
    - Applied kinesiology;
    - Rolfing;
    - Prolotherapy; and
    - Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.



## V. Exclusions and Limitations

10. 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 including TMJ dysfunction. 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 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
11. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision, unless an Obesity Surgery and Treatment (Bariatric) Services Supplemental Rider is purchased by the Group.
12. 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.
13. 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."
14. Diagnosis of infertility, infertility services, including services when the infertility is caused by or related to voluntary sterilization; infertility drugs; surgical or medical treatment programs for infertility, including in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and variations of these procedures; any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees) and cryopreservation of donor sperm and eggs, unless an Infertility Services Supplemental Rider is purchased by the Group.
15. Reversal of male and female voluntary sterilization procedures.
16. Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
17. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
18. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement, under "Section II. Enrollment and Effective Date of Coverage."
19. Non-medical counseling or ancillary services including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities or mental retardation.
20. Therapy or treatment intended primarily to improve or maintain general physical condition for the purpose of enhancing job, school, athletic or recreational performance.
21. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of "Section IV. Covered Services and Supplies."
22. Private hospital rooms, unless determined to be Medically Necessary by the Healthplan Medical Director.
23. 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.



## V. Exclusions and Limitations

24. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs, except as provided in the "External Prosthetic Appliances and Devices" section of "Section IV. Covered Services and Supplies."
  25. 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.
  26. 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.
  27. Chiro Care Services, unless a Supplemental Rider is purchased by the Group.
  28. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery), unless a Vision Care Services Supplemental Rider is purchased by the Group.
  29. Routine refraction, unless a Vision care Services Supplemental Rider is purchased by the Group.
  30. Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
  31. Treatment by acupuncture.
  32. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies," unless a Supplemental Prescription Drug Rider is purchased by the Group.
  33. 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.
  34. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
  35. 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.
  36. Dental implants for any condition.
  37. 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.
  38. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
  39. Cosmetics, dietary supplements and health and beauty aids. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
  40. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
  41. Telephone, e-mail and internet consultations, except for Telehealth and Telemedicine Medical Services.
  42. Massage Therapy.
- In addition to the provisions of this "Exclusions and Limitations" section, you will be responsible for payments on a fee-for-service basis for Services and Supplies under the conditions described in the "Reimbursement" provision of "Section VI. Other Sources of Payment for Services and Supplies."

### Limitations

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



# VI. Other Sources of Payment for Services and Supplies

## 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.

To the extent permitted by law, we may recover from the third party the cost of the care which we have provided for you; and

We have the right to recover from the third party to the extent of 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.

### Reimbursement

If you receive any payment from any third party, including, but not limited to, any worker's compensation fund or carrier, Medicare, a tortfeasor, or any other insurance carrier, 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 prevailing rates 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 them:

##### Plan

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

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

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

##### Closed Panel Plan

A Plan that provides health benefits primarily in the form of services through a panel of employed or contracted providers and that limits



## VI. Other Sources of Payment for Services and Supplies

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 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



## VI. Other Sources of Payment for Services and Supplies

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



## VI. Other Sources of Payment for Services and Supplies

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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.

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## VII. Termination of Your Coverage

### 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. You omit, misrepresent, or provide materially false information in the Enrollment Application; in which case, we may render coverage of a Membership Unit to be null and void from the effective date of coverage. We will give fifteen (15) days written notice prior to terminating coverage;
2. You permit a non-Member to use your CIGNA HealthCare ID card or to falsely obtain Services and Supplies. We will give fifteen (15) days written notice prior to terminating coverage;
3. You obtain or attempt to obtain Services and Supplies by means of false, misleading or fraudulent information, acts or omissions. We will give fifteen (15) days written notice prior to terminating coverage;
4. You fail to pay any Copayment, or any other amount due as a result of receiving Services and Supplies. We will give thirty (30) days written notice prior to terminating coverage;
5. You fail to establish a satisfactory Physician/patient relationship with any Participating Physician after we assist you in establishing such a relationship. We will give thirty (30) days written notice prior to terminating coverage;
6. Your behavior, in our sole opinion, is disruptive, unruly, abusive or uncooperative to such an extent that we are seriously impaired in our ability to provide services to you or to any other Member. We may terminate coverage immediately;
7. You threaten the life or wellbeing of any Healthplan employee, Participating

Provider, or another Member. We may terminate coverage immediately; or

8. You no longer live, reside or work in the Service Area. We may terminate coverage immediately subject to any applicable continuation of coverage provisions.

In no event, however, will we terminate your coverage due to health status or utilization of Services and Supplies.

#### 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 last day of the month following the date the Group provides notice to us of your loss of eligibility, and we shall have no further obligation to provide Services and Supplies.

#### Termination By Termination of This Agreement

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

1. Termination for Non-Payment of Prepayment Fees. We may terminate this Agreement for the Group’s non-payment of any Prepayment Fees owed to us if the Prepayment Fees are not paid to us by the end of the Grace Period.
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



## VII. Termination of Your Coverage

purchase a type of coverage currently being offered in that market.

3. Termination for Material Change by the Healthplan. The Group may terminate this Agreement upon thirty (30) days prior written notice to us in the case of us making a material change to any provisions we are required to disclose to the Group or its Members.
4. 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.
5. 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.
6. Termination Due to Association Membership Ceasing. If this Agreement covers an association, we may terminate this Agreement upon thirty (30) days prior notice to the Group 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.
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.
8. Termination for No Eligible Membership. We may terminate this Agreement upon thirty (30) days prior written notice to the Group if no Members of the Group reside, live or work in the Service Area.

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 Prepayment Fees. In the case of non-payment of

Prepayment Fees, the written termination notice will be issued at the end of the Grace Period and the Agreement shall terminate immediately upon our written notice to the Group.

Notice of Termination to Members. If this Agreement is terminated for any reason in this section, the Group shall notify Subscribers and, if required by law, Dependents of the termination effective date and any applicable rights Members may have.

Responsibility for Payment. The Group shall be responsible for the payment of all Prepayment Fees due through the date on which coverage ceases under this “Termination by Termination of This Agreement” section. 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 Subscribers and, if required by law, Dependents, prior to such date, the Group shall also be financially responsible for, and shall submit to the Healthplan, all Prepayment Fees due through the extended coverage termination date determined by Group’s proper notice. Prepayment Fees due from the Group under this paragraph shall be calculated on a pro-rated basis for less than a full calendar month of coverage.

### **Certification of Creditable Coverage Upon Termination**

We will issue you a Certification of Creditable Group Health Plan Creditable 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; and
3. When you make a request within twenty-four (24) months after the date coverage expires under either of the above two situations.



## VIII. Continuation of Coverage

### Section VIII. Continuation of Coverage

#### Continuation of Group Coverage under COBRA

##### Introduction

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

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

##### COBRA Continuation Coverage

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

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

Plan because either one of the following qualifying events happens:

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

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

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

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

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

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



## VIII. Continuation of Coverage

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

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

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

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

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

### **If the Plan provides retiree health coverage**

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

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

### **Disability extension of 18-month period of continuation coverage**

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

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

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



## VIII. Continuation of Coverage

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

### Early Termination of COBRA Continuation

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

### Cost of COBRA Continuation Coverage

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

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

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

[www.doleta.gov/tradeact/2002act\\_index.asp](http://www.doleta.gov/tradeact/2002act_index.asp).

### Conversion Available Following Continuation

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

### Service Area Restrictions

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

### If You Have Questions

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

### Keep Your Plan Informed of Address Changes

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



## VIII. Continuation of Coverage

### 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 Coverage for Certain Dependents Under Texas Law

A Dependent of a Subscriber who continues to live, reside or work in the Service Area, and who has an Event Creating Eligibility, is eligible to continue coverage for himself for a maximum of thirty-six (36) months.

An Event Creating Eligibility for a Dependent to continue coverage under this provision is:

- a) the severance of the family relationship with Subscriber by way of divorce or attainment of the limiting age;
- b) the retirement the Subscriber; or
- c) the death of the Subscriber.

It is the Subscriber's responsibility to give written notification to the Group of any events as described in (a) or (b) within fifteen (15) days of the event. The Dependent may also notify the Group of these events described in (a), (b) or (c).

To obtain continuation coverage under this provision, the Dependent:

- a) must have been continuously covered as a Member of the Group for period of at least one year or must be an infant child under one year of age; and
- b) must give written notice to the Group of the desire to continue coverage, complete any necessary enrollment forms and pay the Group the premium within sixty (60) days from the Event /Creating Eligibility.

The Group is required to notify the Dependent in writing of the option to continue coverage and the duties of continuing coverage immediately after receiving notification of the Event Creating Eligibility.

During the sixty (60) day election period as described in (b) above, coverage under this Agreement will be continued, provided premiums are paid by the Group. At no time will the administrative fee for this coverage exceed five dollars (\$5.00) per month. This fee may be charged in excess of the premium.

Continuation of coverage under this provision will end on the earliest of the following dates:

- a) the date thirty-six (36) months after the date of the Event Creating Eligibility;
- b) the date ending the period for which the Dependent makes his last required contribution;
- c) the date the Dependent becomes or is eligible for Medicare;
- d) the date the Dependent becomes eligible for similar benefits under any arrangement of coverage; or
- e) the date, within one year of the date creating eligibility, that the Group replaces this Agreement. In this case the Dependent may receive benefits under the replacement agreement.

Dependents that no longer reside within the Service Area, but continue to reside in the State of Texas and have properly elected continuation of coverage under this provision, are only entitled to out-of-area emergency benefits while residing outside of the Service Area.

### Continuation of Coverage

Any Member who has completed a continuation of coverage period provided under COBRA or any Dependent who has completed a continuation of coverage period provided to Dependents in accordance with Texas state law may elect to continue coverage for an additional six (6) months, as follows.

A Subscriber and Dependent who continue to live, reside or work in the Service Area, are eligible to continue coverage for six (6) months if they have lost coverage under this Agreement for any reason, including discontinuance of this Agreement except as noted below. To obtain continuation coverage under this provision, the Subscriber or Dependent:

- a) must have been continuously covered under this Agreement, or similar benefits under any other



## VIII. Continuation of Coverage

group policy that was replaced by this Agreement, during the period of three (3) consecutive months immediately prior to termination; and

- b) must file a written election of continuation coverage with the Group and pay the Group the premium within thirty-one (31) days of the later of: (i) the date the Group coverage would have been otherwise terminated; or (ii) the date the Group gave Subscriber and/or Dependent notice of the right to continuation of coverage.

The Group is required to notify the Subscriber and/or Dependents, in writing, of the duties as described in (b) no later than the date on which coverage would otherwise terminate.

Continuation Coverage shall not be available if termination of coverage occurred because:

- (1) after reasonable notice, the Subscriber failed to make any required contribution toward monthly payment;
- (2) the Subscriber or Dependent is or could be covered by similar group coverage which replaced coverage under this Agreement within thirty-one (31) days after termination of coverage under this Agreement;
- (3) the Subscriber or Dependent is or could be covered by Medicare;
- (4) the Subscriber or Dependent is or could be covered by any other insured or non-insured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination; or
- (5) the Subscriber or Dependent is eligible for COBRA continuation of coverage.

Continuation Coverage will end on the earliest of the following dates:

- (1) the date six (6) months after the date the Subscriber's or Dependent's coverage under this Agreement would have otherwise terminated;
- (2) the date ending the period for which the Subscriber or Dependent last makes his required contribution;

- (3) the date the Subscriber or Dependent becomes or is eligible for similar benefits under any arrangement for coverage on a group basis;
- (4) the date the Subscriber or Dependent becomes or is eligible for Medicare;
- (5) the date the Subscriber or Dependent legally resides outside of the Service Area;
- (6) the date on which this Agreement with the Group is terminated.

At the end of the six-month Continuation Coverage term, the Subscriber or Dependent may be eligible for coverage through the Texas Health Insurance Risk Pool by calling Member Services at the number on your ID Card or by calling the Texas Risk Pool directly at 888-398-3927.

### Availability of Coverage Through the Texas Health Insurance Risk Pool

A Member, who continues to reside in the Service Area, but has lost eligibility for any reason including the expiration of the applicable coverage period under Continuation Coverage, COBRA, etc., may apply within thirty-one (31) days of the loss of eligibility through the Texas Health Insurance Risk Pool. The Member may apply to the Texas Health Insurance Risk Pool for coverage by calling Member Services at the number on your ID card or by calling the Texas Risk Pool directly at 888-398-3927.

### Continuation of Coverage Under FMLA

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

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.



## VIII. Continuation of Coverage

### 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.

You and your Dependents will be subject to only the balance of a 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.

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### 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 certificate.

### Reinstatement of Benefits

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



### Section IX. Miscellaneous

#### Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to our Members for the purpose of promoting the general health and well being of our Members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Group. Contact 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. The Healthplan may, at its option, make payment to the Subscriber for any cost of any covered Services and Supplies received by the Subscriber or Subscriber's covered Dependents from a non-participating provider. If the Healthplan makes payment to the Subscriber, the Subscriber is responsible for reimbursing the non-participating provider.

#### Clerical Error

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

#### Entire Agreement

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

Agreement and other collaterals, the terms of the Group Service Agreement shall govern.

#### No Implied Waiver

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

#### Notice

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

#### Records

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

#### 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.



### Service Marks

The CIGNA HealthCare 24 Hour Health Information Line<sup>SM</sup> and CIGNA Lifesource Organ Transplant Network<sup>®</sup> are registered service marks of CIGNA Corporation.

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## Supplemental Rider

### Chiropractic Care Services Coverage

This Supplemental Rider is a part of the CIGNA HealthCare of Texas, Inc. Group Service Agreement (“the Agreement”) and is subject to all the terms, conditions and limitations contained therein. The following supplemental Chiropractic Care Services benefit is added to the Agreement.

#### 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 need a referral from your PCP.

The following are specifically excluded from chiropractic care services:

Services of a chiropractor which are not within his scope of practice, as defined by state law;

Charges for care not provided in an office setting;

Maintenance or preventive treatment consisting of routine, long term or non-medically necessary care provided to prevent re-occurrences or to maintain the patient’s current status; and

Vitamin therapy.

Coverage for chiropractic care services is subject to a copayment as follows:

Services	Copayments
<p><b>Chiropractic Care Services</b></p> <p>Services provided on an outpatient basis are limited to 20 day maximum per Member per Contract Year</p>	<p>\$50 Copayment per office visit</p>



## Schedule of Copayments

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

It is recommended that you review your Group Service Agreement for an exact description of the Services and Supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage. Please see the last page of this document for a definition of terms that are noted in this Schedule of Copayments and are not defined in the Group Service Agreement.

Covered Services and Supplies	Copayments
<p><b>Physician Services</b></p> <p><b>Primary Care Physician Office Visit, including:</b>            Preventive Care            Adult Medical Care            Periodic Physical Evaluation for Adults            Well-Child Care            Routine Immunizations and Injections*            Surgery Performed in the Physician’s Office</p> <p><b>Specialty Care Physician Office Visit, including:</b>            Office Visits            Surgery Performed in the Physician’s Office</p>	<p>\$25 Copayment per office visit</p> <p>The office visit Copayment will be waived when immunization is the only service provided</p> <p>*No Copayment will be charged for children birth through age 6</p> <p>\$50 Copayment per office visit</p>
<p><b>Inpatient Hospital Services, including:</b>            Semi Private Room and Board            Physician and Surgeon Charges            Laboratory, Radiology and other Diagnostic and Therapeutic Services            Administered Drugs, Medications, Biologicals and Fluids            Special Care Units            Operating Room, Recovery Room            Anesthesia            Inhalation Therapy            Radiation Therapy and Chemotherapy</p>	<p>\$1,000 Copayment per admission</p>



Covered Services and Supplies	Copayments
<p><b>Outpatient Facility Services, including:</b>            Operating Room, Recovery Room,            Procedures Room, and Treatment Room including              Physician Services              Laboratory and Radiology Services              Administered Drugs, Medications, Biologicals                and Fluids              Anesthesia              Inhalation Therapy</p>	<p>\$500 Copayment per facility use</p>
<p><b>Emergency and Urgent Care Services, including:</b></p> <p><b>Physician's Office</b></p> <p><b>Hospital Emergency Room</b></p> <p><b>Urgent Care Facility or Outpatient Facility</b></p>	<p>Same as Physician Office Visit Copayment</p> <p>\$250 Copayment per visit</p> <p>The emergency room Copayment will be waived if you are admitted to a participating hospital directly from the emergency room</p> <p>\$125 Copayment per visit</p> <p>The urgent care facility Copayment will be waived if you are admitted to a participating hospital directly from the urgent care facility.</p>
<p><b>Ambulance Services</b></p>	<p>No Charge</p>
<p><b>Anesthesia for Dental Treatment</b></p>	<p>Same as Physician Office Copayment or Outpatient Facility Copayment, as applicable</p>
<p><b>Bone Mass Measurement, Hearing Screening for Newborns and Prostate Cancer Test</b></p>	<p>Same as Physician Office Copayment, Outpatient Facility Copayment or Inpatient Hospital Copayment, as applicable</p>



<b>Covered Services and Supplies</b>	<b>Copayments</b>
<b>Diabetic Services and Supplies, including:</b>	
<b>Self Management Courses</b>	Same as Physician Office Visit Copayment
<b>Equipment</b>	Same as Durable Medical Equipment Copayment
<b>Insulin and other Diabetic Pharmaceutical Supplies</b>	Same as Prescription Drug Copayment
<b>Durable Medical Equipment</b>	No Charge
<b>External Prosthetic Appliances and Devices</b>	No Charge
<b>Family Planning Services, including:</b>	
<b>Office Visits (Tests, Counseling)</b>	Same as Physician Office Visit Copayment
<b>Surgical Sterilization Procedures</b>	Same as Inpatient Hospital, Outpatient Facility or Physician Office Visit Copayment, depending on facility used
<b>Home Health Services</b>	No Charge
<b>Hospice Services, including:</b>	
<b>Inpatient Services</b>	No Charge
<b>Outpatient Services</b>	No Charge
<b>Internal Prosthetic/Medical Appliances</b>	No Charge for Appliance.
<b>Inpatient Services at Other Participating Health Care Facilities, including:</b>	
<b>Rehabilitation Hospital</b>	No Charge
<b>Skilled Nursing Facility and Sub-Acute Facilities</b>	No Charge



Covered Services and Supplies	Copayments
<b>Laboratory and Radiology Services, including:</b>	
<b>Advanced Radiological Imaging</b> (MRIs, MRAs, CAT scans, PET scans, etc.)	No Charge
<b>Other Laboratory and Radiology Services</b>	
Outpatient Hospital Facility	No Charge
Independent Facility	No Charge
<b>Maternity Care Services, including:</b>	
<b>Initial Office Visit to Confirm Pregnancy</b>	Same as Physician Office Visit Copayment
<b>All other Office Visits</b>	No Charge
<b>Delivery</b>	Same as Inpatient Hospital Copayment
<b>Mental Health Services, including:**</b>	
<b>Inpatient Mental Health Services</b>	Same as Inpatient Hospital
<b>Outpatient Individual Mental Health Services</b> <i>Deductible, if any, does not apply.</i>	\$25 Copayment per office visit
<b>Outpatient Mental Health Group Therapy</b> <i>Deductible, if any, does not apply.</i>	\$25 Copayment per office visit
<b>Mental Health Intensive Outpatient Therapy Programs</b> <i>Deductible, if any, does not apply.</i>	\$25 Copayment per office visit
<b>Chemical Dependency Services, including:**</b>	
<b>Inpatient Chemical Dependency Services</b>	Same as Inpatient Hospital
<b>Outpatient Individual Chemical Dependency Services</b> <i>Deductible, if any, does not apply.</i>	\$25 Copayment per office visit



# Schedule of Copayments

Covered Services and Supplies	Copayments
<p><b>Outpatient Group Chemical Dependency Services</b></p> <p><i>Deductible, if any, does not apply.</i></p>	\$25 Copayment per office visit
<p><b>Chemical Dependency Intensive Outpatient Therapy Programs</b></p> <p><i>Deductible, if any, does not apply.</i></p>	\$25 Copayment per office visit
<b>Serious Mental Illness, including:**</b>	
<b>Inpatient Serious Mental Illness Services</b>	Same as Inpatient Hospital
<p><b>Outpatient Serious Mental Illness Services</b></p> <p><i>Deductible, if any, does not apply.</i></p>	\$25 Copayment per office visit
<p><b>Intensive Outpatient Therapy Programs</b></p> <p><i>Deductible, if any, does not apply.</i></p>	\$25 Copayment per office visit
<p><b>Nutritional Evaluation</b></p> <p>3 visit maximum per Member per Contract Year</p>	Same as Physician's Office Visit Copayment
<p><b>Transplant Travel Services Maximum</b></p> <p>\$10,000 maximum benefit</p>	
<b>Rehabilitative Therapy</b>	\$50 Copayment per office visit
<b>Temporomandibular Joint Dysfunction Services</b>	Same as Physicians Office Copayment or Outpatient Facility Copayment, as applicable

Basic Health Services Copayment Maximum *	
<b>Individual Member Basic Health Services Copayment Maximum</b>	\$2,500 per Contract Year
<b>Membership Unit Basic Health Services Copayment Maximum</b>	\$5,000 per Contract Year

\*Basic Health Services Copayment Maximums:

In no event shall any Copayment charged for any single Basic Health Service exceed the lesser of: (1) the Copayment amount for the Basic Health Service shown in the Schedule of Copayments; or (2) fifty percent (50%) of the total cost of





## Amendment to the Group Service Agreement

**Group:** MHMRA of Harris County

**Amendment Effective Date:** January 1, 2011

The Group Service Agreement (“Agreement”) provided by CIGNA HealthCare of Texas, Inc. (“Healthplan”) to which Amendment is attached and incorporated therein, is hereby amended as described below.

1. In the **SCHEDULE OF COPAYMENTS** to the Group Service Agreement, the following change is made to the Mental Health Services and Chemical Dependency Services benefit:

<b><i>Covered Services and Supplies</i></b>	<b><i>Copayments</i></b>
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**Mental Health Services, including: \*\***

<b>Inpatient Mental Health Services</b>	\$500 Copayment per admission
<b>Outpatient Individual Mental Health Services</b>	\$35 Copayment per visit
<b>Outpatient Mental Health Group Therapy</b>	\$35 Copayment per visit
<b>Mental Health Intensive Outpatient Therapy Programs</b>	\$35 Copayment per visit

**Chemical Dependency Services, including: \*\***

<b>Inpatient Chemical Dependency Services</b>	\$500 Copayment per admission
<b>Outpatient Individual Chemical Dependency Services</b>	\$35 Copayment per visit
<b>Outpatient Group Chemical Dependency Services</b>	\$35 Copayment per visit
<b>Chemical Dependency Intensive Outpatient Therapy Programs</b>	\$35 Copayment per visit



# Amendment to the Group Service Agreement

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**Serious Mental Illness, including: \*\***

<b>Inpatient Serious Mental Illness Services</b>	Same as Inpatient Hospital Copayment
<b>Outpatient Serious Mental Illness Services</b>	\$35 Copayment per visit
<b>Intensive Outpatient Therapy Programs</b>	\$35 Copayment per visit

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

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## Supplemental Rider

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

## Prescription Drugs

### I. Definitions

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

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

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

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

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

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

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

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

### II. Services and Benefits

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

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

### III. Limitations

Each Prescription Order or refill shall be limited as follows:

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

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



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

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

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

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Agreement, by submitting a written request stating why the Prescription Drug or Related Supply should be covered. You may also initiate an appeal by calling the toll-free number on the CIGNA HealthCare ID card. If so, an appeal form will be sent to you.

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

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

data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

#### IV. Member Payments

Coverage for Prescription Drugs and Related Supplies is subject to a Copayment, Deductible and Contract Year Maximum if any. The applicable Copayments, Deductibles and Maximums if any are identified in the Prescription Drug Schedule of Copayments. In no event will the Copayment exceed the retail cost of the Prescription Drug or Related Supply.

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

#### V. Exclusions

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

1. Any drugs available over the counter that do not require a prescription by Federal or State Law, and any drug that is a pharmaceutical alternative to an over the counter drug other than insulin.
2. Any drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee.
3. Injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised injectable drugs: injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
4. Any drugs that are experimental or investigational, within the meaning set forth in the Agreement.



5. Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information or The American Hospital Formulary Service Drug Information) or in medical literature, or in compendium approved by the Texas Insurance Commissioner. Medical literature means scientific studies published in a peer-reviewed national professional medical journal.
6. Any prescription and non-prescription supplies (such as, ostomy supplies), devices, and appliances other than Related Supplies.
7. Implantable contraceptive products, except as covered in the Agreement.
8. Any fertility drug.
9. Any drugs used for treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.
10. Any prescription vitamins (other than pre-natal vitamins), dietary supplements and fluoride products.
11. Drugs used for cosmetic purposes, such as, drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products.
12. Any diet pills or appetite suppressants (anorectics).
13. Prescription smoking cessation products.
14. Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
15. Replacement of Prescription Drugs and Related Supplies due to loss or theft.
16. Drugs used to enhance athletic performance.
17. Drugs which are to be taken by or administered to a Member while the Member is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its

premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.

18. Prescriptions more than one year from the original date of issue.

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## Prescription Drug Schedule of Copayments

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

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

## FEDERAL REQUIREMENTS

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

### Coverage of Students on Medically Necessary Leave of Absence

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

Coverage will terminate on the earlier of:

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

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

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

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

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

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

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

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

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

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

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

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

## Effect of Section 125 Tax Regulations on This Plan

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

### A. Coverage Elections

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

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

### B. Change of Status

A change in status is defined as:

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

### C. Court Order

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

### D. Medicare or Medicaid Eligibility/Entitlement

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

### E. Change in Cost of Coverage

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

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

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

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