SERIAL 01178 RFP EMPLOYEE HEALTH BENEFITS PLAN

DATE OF LAST REVISION: August 29, 2005 CONTRACT END DATE: June 30, 2007

CONTRACT PERIOD THROUGH **JUNE 30, 2007**
~~DECEMBER 31, 2005~~
~~DECEMBER 31, 2004~~
~~DECEMBER 31, 2003~~

TO: All Departments

FROM: Department of Materials Management

SUBJECT: Contract for **EMPLOYEE HEALTH BENEFITS PLAN**

Attached to this letter is published an effective purchasing contract for products and/or services to be supplied to Maricopa County activities as awarded by Maricopa County on **January 01, 2003.**

All purchases of products and/or services listed on the attached pages of this letter are to be obtained from the vendor holding the contract. Individuals are responsible to the vendor for purchases made outside of contracts. The contract period is indicated above.

_____
Wes Baysinger, Director
Materials Management

SD/mm
Attach

Copy to: Clerk of the Board
Mike Schaiberger, **Total Compensation**
Pat Vancil, **Total Compensation**
Diane Golat, **Total Compensation**
Mirheta Muslic, Materials Management

(Please remove Serial 97025-MS from your contract notebooks)

CONTRACT FOR SERVICES PURSUANT TO RFP

SERIAL 01178-RFP

This Contract is entered into this 19th day of August, 2002 by and between Maricopa County ("County"), a political subdivision of the State of Arizona, and CIGNA HealthCare of Arizona, Inc., an Arizona corporation ("Contractor") for the purchase of General Medical Health Benefits and Services.

1.0 TERM

1.1 This Contract is for a term of one (1) year, beginning on the 1st day of January 2003 and ending the 31st day of December ~~2003~~ ~~2004-2005~~ **June 30, 2007**.

1.2 The County may, at its option and with the agreement of the Contractor, extend the period of this Contract for additional one (1) year terms up to a maximum of Nine (9) additional terms. The County shall notify the Contractor in writing of its intent to extend the Contract period at least one hundred and twenty (120) calendar days prior to the expiration of the original contract period, or any additional term thereafter.

2.0 PAYMENT

2.1 As consideration for performance of the duties described herein, County shall pay Contractor the sum stated in Final Pricing, attached hereto and incorporated herein as Exhibit "A".

2.2 Payment under this Contract shall be made in the manner provided by law. Invoices shall contain the following information: description of services, quantities, unit prices, and extended totals and applicable sales/use tax. The County is not subject to excise tax.

2.3 County shall not be responsible to contractor for mistakes discovered after ninety (90) days.

3.0 DUTIES

3.1 The Contractor shall perform all duties stated in the Agreed Scope of Work, attached hereto and incorporated herein as "Exhibit B, Exhibit B-1 (Best and Final Clarifications), Exhibit B-2 (Plan Design) Exhibit B-3, Exhibit B-4, Exhibit B-5 Performance Guarantee Metrics and Exhibit B-6 Performance Incentive Program."

4.0 TERMS & CONDITIONS

4.1 INDEMNIFICATION AND INSURANCE:

4.1.1 <u>Indemnification.</u>

To the fullest extent permitted by law, Contractor shall defend, indemnify, and hold harmless the County, its agents, representatives, officers, directors, officials, and employees from and against all claims, damages, losses and expenses, including but not limited to attorney fees and costs, relating to this Contract.

Contractor will indemnify and hold the County harmless from and against all extra-contractual (non-benefit) costs, damages, judgment, attorneys' fees, expenses and liabilities of any kind or nature which occur as the result of:

i. Contractor's gross negligence or intentional wrongdoing with respect to the administration of claims under the County's Plan;
ii. The negligent or intentionally wrongful acts or omissions of medical providers if such providers are employees of Contractor or its affiliates to the extent that such acts or omissions arise out of such providers' participation in Contractor provider networks; and/or
iii. The negligent or intentionally wrongful acts or omission s of Contractor or its employees with respect to the performance of other network management responsibilities of contractor under this Agreement.

Notwithstanding the above, Contractor's duty to indemnify and hold County harmless shall not extend to the acts or omissions of the County, its officers, directors, or employees or to acts or omissions of non-employee participating providers who provide services in any network for County's Plan hereunder.

The amount and type of insurance coverage requirements set forth herein will in no way be construed as limiting the scope of the indemnity in this paragraph.

The scope of this indemnification does not extend to the negligence of the County.

4.1.2 Insurance Requirements.

Contractor, at its own expense, shall purchase and maintain the herein stipulated minimum insurance with companies duly licensed, possessing a current A.M. Best, Inc. Rating of B++6, or approved unlicensed companies in the State of Arizona with policies and forms satisfactory to the County.

All insurance required herein shall be maintained in full force and effect until all work or service required to be performed under the terms of the Contract is satisfactorily completed and formally accepted. Failure to do so may, at the sole discretion of the County, constitute a material breach of this Contract.

The Contractor's insurance shall be primary insurance as respects the County, and any insurance or self-insurance maintained by the County shall not contribute to it.

Any failure to comply with the claim reporting provisions of the insurance policies or any breach of an insurance policy warranty shall not affect coverage afforded under the insurance policies to protect the County.

The Contractor shall be solely responsible for the deductible and/or self-insured retention.

The insurance policies required by this Contract, except Workers' Compensation, shall name the County, its agents, representatives, officers, directors, officials and employees as Additional Insureds.

The insurance policies required hereunder, except Workers' Compensation, shall contain a waiver of transfer of rights of recovery (subrogation) against the County, its agents, representatives, officers, directors, officials and employees for any claims arising out of Contractor's work or service.

4.1.2.1 *Commercial General Liability*. Contractor shall maintain Commercial General Liability insurance with a limit of not less than $1,000,000 for each occurrence with a $2,000,000 Products/Completed Operations Aggregate and a $2,000,000 General Aggregate Limit. The policy shall include coverage for bodily injury, broad form property damage, personal injury, products and completed operations and blanket contractual coverage including, but not limited to, the liability assumed under the indemnification provisions of this Contract which coverage will be at least as broad as Insurance Service Office, Inc. Policy Form CG 00 01 10 93 or any replacements thereof.

The policy shall contain a severability of interest provision, and shall not contain a sunset provision or commutation clause, or any provision which would serve to limit third party action over claims.

The Commercial General Liability additional insured endorsement shall be at least as broad as the Insurance Service Office, Inc.'s Additional Insured, Form CG 20 10 11 85, and shall include coverage for Contractor's operations and products and completed operations.

4.1.2.2 *Automobile Liability*. Contractor shall maintain Automobile Liability insurance with a combined limit for bodily injury and property damage of no less than $1,000,000, each occurrence, with respect to Contractor's vehicles (whether owned, hired, non-owned), assigned to or used in the performance of this Contract.

4.1.2.3 *Workers' Compensation*. The Contractor shall carry Workers' Compensation insurance to cover obligations imposed by federal and state statutes having jurisdiction of Contractor's employees engaged in the performance of the work or services, as well as Employer's Liability insurance of not less than $1,000,000 for each accident, $1,000,000 disease for each employee, and $1,000,000 disease policy limit.

If any work is subcontracted, the Contractor will require Subcontractor to provide Workers' Compensation and Employer's Liability insurance to at least the same extent as required of the Contractor.

4.1.3 Certificates of Insurance.

4.1.3.2 Prior to commencing work or services under this Contract, Contractor shall furnish the County with certificates of insurance issued by Contractor's insurer(s), as evidence that policies providing the required coverage, conditions and limits required by this Contract are in full force and effect. Such certificates shall identify this contract number and title.

In the event any insurance policy (ies) required by this Contract is (are) written on a "claims made" basis, coverage shall extend for two years past completion and acceptance of the Contractor's work or services and as evidenced by annual Certificates of Insurance.

If a policy does expire during the life of the Contract, a renewal certificate must be sent to the County fifteen (15) days prior to the expiration date.

4.1.4 Cancellation and Expiration Notice.

Insurance required herein shall not be permitted to expire, be canceled, or materially changed without thirty- (30) day's prior written notice to the County.

4.2 NOTICES:

All notices given pursuant to the terms of this Contract shall be addressed to:

For County:

Maricopa County
Department of Materials Management
Attn: Director of Purchasing
320 West Lincoln Street
Phoenix, Arizona

For Contractor:

CIGNA HealthCare of Arizona, Inc.
11001 North Black Canyon Hwy, 4th Floor
Phoenix, AZ. 85029

Attn: Vice President, General Manager
Arizona HealthPlan

4.3 ESCALATION:

Any requests for reasonable price adjustments must be submitted two hundred and ten (210) days prior to the then Contract period's expiration date. Requests for adjustment must be supported by appropriate documentation. The **Not to Exceed** cap on the proposed upcoming year's rates are due the first of January of the year preceding with final firm rates due 180 days prior to the effective year. If County agrees to the adjusted rates, County shall issue written approval of the change. The reasonableness of the request will be determined by the claims experience and/or by performing a market survey.

4.4 TERMINATION:

County may unconditionally terminate this Contract for convenience by providing thirty (30) calendar days advance notice to the Contractor.

County may terminate this Contract if Contractor fails to pay any charge when due or fails to perform or observe any other material term or condition of the Contract, and such failure continues for more than ten (10) days after receipt of written notice of such failure from County, or if Contractor becomes insolvent or generally fails to pay its debts as they mature.

4.5 STATUTORY RIGHT OF CANCELLATION FOR CONFLICT OF INTEREST:

Notice is given that pursuant to A.R.S. § 38-511 the County may cancel this Contract without penalty or further obligation within three years after execution of the contract, if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the County is at any time while the Contract or any extension of the Contract is in effect, an employee or agent of any other party to the Contract in any capacity or consultant to any other party of the Contract with respect to the subject matter of the Contract. Additionally, pursuant to A.R.S § 38-511 the County may recoup any fee or commission paid or due to any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the County from any other party to the contract arising as the result of the Contract.

4.6 OFFSET FOR DAMAGES;

In addition to all other remedies at law or equity, the County may offset from any money due to the Contractor any amounts Contractor owes to the County for damages resulting from breach or deficiencies in performance under this contract.

4.7 ADDITIONS/DELETIONS OF SERVICE:

The County reserves the right to add and/or delete products and/or services provided under this Contract. If a requirement is deleted, payment to the Contractor will be reduced proportionately to the amount of service reduced in accordance with the bid price. If additional services and/or products are required from this Contract, prices for such additions will be negotiated between the Contractor and the County.

4.8 SUBCONTRACTING:

The Contractor may not assign this Contract or subcontract to another party for performance of the terms and conditions hereof without the written consent of the County, which shall not be unreasonably withheld. All correspondence authorizing subcontracting must reference the Bid Serial Number and identify the job project.

4.9 AMENDMENTS:

All amendments to this Contract must be in writing and signed by both parties.

4.10 RETENTION OF RECORDS:

The Contractor agrees to retain all financial books, records, and other documents relevant to this Contract for five (5) years after final payment or until after the resolution of any audit questions which could be more than five (5) years, whichever is longer. The County, Federal or State auditors and any other persons duly authorized by the Department shall have full access to, and the right to examine, copy and make use of, any and all said materials.

If the Contractor's books, records and other documents relevant to this Contract are not sufficient to support and document that requested services were provided, the Contractor shall reimburse Maricopa County for the services not so adequately supported and documented.

4.11 AUDIT DISALLOWANCES:

If at any time County determines that a cost for which payment has been made is a disallowed cost, such as overpayment, County shall notify the Contractor in writing of the disallowance. County shall also state the means of correction, which may be but shall not be limited to adjustment of any future claim submitted by the Contractor by the amount of the disallowance, or to require repayment of the disallowed amount by the Contractor.

4.12 VALIDITY:

The invalidity, in whole or in part, of any provision of the Contract shall not void or affect the validity of any other provision of this Contract.

4.13 RIGHTS IN DATA:

The County shall have the use of data and reports resulting from this Contract without additional cost or other restriction except as provided by law. Each party shall supply to the other party, upon request, any available information that is relevant to this Contract and to the performance hereunder.

4.14 INTEGRATION

This Contract represents the entire and integrated agreement between the parties and supersedes all prior negotiations, proposals, bids, communications, understandings, representations, or agreements, whether oral or written, express or implied.

4.15 GOVERNING LAW:
The laws of the State of Arizona will govern this contract.

IN WITNESS WHEREOF, this Contract is executed on the date set forth above.

CONTRACTOR

_____
AUTHORIZED SIGNATURE

_____
PRINTED NAME AND TITLE

_____
ADDRESS

_____
DATE

MARICOPA COUNTY

BY: _____ _____
CHAIRMAN, BOARD OF SUPERVISORS DATE

ATTESTED:

_____ _____
CLERK OF THE BOARD DATE

APPROVED AS TO FORM:

_____ _____
MARICOPA COUNTY ATTORNEY DATE

CIGNA Healthcare - Stand Alone Medical Quote Only

EXHIBIT A
BEST and Final Offer (July 8, 2002)
1.0 PRICING:
1.1 General Medical

		2003 / **2004** Monthly Rate			
		Plan A: HMO	Plan B: POS	Plan C: PPO	Maximum % Increase 2004
1.1.1 Fully Insured	Employee Only	~~$225.29~~ **$273.73**	~~$237.57~~ **$291.02**	~~$289.64~~ **$376-53**	*See Notes Below*
	Employee + Children	~~$370.34~~ **$449.96**	~~$390.64~~ **$478.18**	~~$476.52~~ **$619.48**	*See Notes Below*
	Employee + Spouse	~~$450.64~~ **$547.53**	~~$475.25~~ **$582.18**	~~$579.34~~ **$753.14**	*See Notes Below*
	Employee + Family	~~$596.95~~ **$725.29**	~~$629.59~~ **$771.25**	~~$767.49~~ **$997.74**	*See Notes Below*
	Pre-65 Retiree	$464.89	$469.79	$532.67	*See Notes Below*
	Pre-65 Retiree + Family	$940.27	$950.54	$1,077.37	*See Notes Below*
	Post-65 Retiree	$464.89	$469.79	$532.67	*See Notes Below*
	Post-65 Retiree + Family	$940.27	$950.54	$1,077.37	*See Notes Below*

	HMO	POS	PPO
Rate Cap Maximum % 2003	21.5%	22.5%	30.0%

Caps will be applied by each medical coverage - on the PPO since this is a new benefit effective 1/1/2003, cap will placed at 30%

EXHIBIT B 01178-RFP-HMO
CIGNA HEALTHCARE OF ARIZONA, INC. (Phoenix)

Face Sheet

to the

CIGNA HEALTHCARE GROUP SERVICE AGREEMENT

which is incorporated herein by reference.

AGREEMENT NUMBER: (3205496) HMO

PARTIES TO AGREEMENT:

HEALTHPLAN: CIGNA HealthCare of Arizona, Inc. (Phoenix)

and

GROUP: Maricopa County

PREPAYMENT FEES AND GRACE PERIOD

On or before the last day of each month, Group shall remit to the Healthplan on behalf of each Subscriber and his Dependents the Prepayment Fee specified as follows in payment for services rendered under this Agreement in the following month. The Healthplan shall permit a grace period of forty-five (45) days during which the Prepayment Fees may be paid without loss of coverage under the Agreement. In the event this Agreement terminates and there are Prepayment Fees due to the Healthplan, the Group will be financially responsible for the Prepayment Fees. This responsibility will be in addition to any other financial obligation of the Group hereunder.

Group shall pay Prepayment Fees each month in the following amounts:

Membership Unit

Prepayment Fee

_____

_____

_____

_____

ENROLLMENT

The Healthplan is only required to consider enrollment applications received by the Healthplan (i) during the Open Enrollment Period or within sixty (60) days thereafter, or (ii) within sixty (60)

days of the event creating eligibility. The Healthplan shall have the right, at reasonable times, to examine Group records, including the payroll records of Subscribers for the purpose of confirming eligibility and appropriate Prepayment Fees under the Agreement.

An individual who did not enroll for coverage under the Agreement during the initial eligibility period or Open Enrollment Period may enroll for coverage in accordance with the "Enrollment after the Open Enrollment Period" provision in "Section II. Enrollment and Effective Date of Coverage" section.

GROUP'S ENROLLMENT/ELIGIBILITY RULES

Group's enrollment and/or eligibility rules for its Subscribers and their Dependents are as follows:

New hires are eligible for coverage upon employers determination.

Full-time students covered until age 25

Children on church mission covered until age 25- Letter from church required

Coverage shall terminate on the last day of the pay period in which premium is paid or in which the employee ceases to be in a benefits eligible position.

Unless otherwise stated above, the eligibility provisions set forth in "Section II. Enrollment and Effective Date of Coverage" section of the Agreement will govern.

DISENROLLMENT

Group shall notify Healthplan of all employment terminations or other losses of eligibility of Subscribers and of losses of eligibility of Dependents ("Notice of Termination"). Unless otherwise required by law, coverage for the Subscribers and/or Dependents shall cease at midnight on the day the loss of eligibility occurs, and Group shall remit Prepayment Fees in accordance to the rules described under the section entitled "Payment Method for Group", through the date coverage ceased, subject to the following rules and exceptions:

1. Notice of Termination must be received by Healthplan within ninety (90) days of the date on which employment termination or loss of eligibility first occurred.
2. If Notice of Termination is not received by Healthplan within ninety (90) days of the date on which employment termination or loss of eligibility first occurred, then coverage shall cease at midnight on the date which is ninety (90) days prior to the date Notice of Termination is received and Group shall be responsible for and shall submit to Healthplan all Prepayment Fees due through the date coverage ceased.

CERTIFICATION OF COVERAGE

Healthplan shall issue Certificates of Group Health Plan Coverage to Members who end coverage with Group, provided that Group reports enrollment, disenrollment and other necessary information to Healthplan, according to transactions arranged between Healthplan and Group. Alternatively, Group may agree in writing to take primary responsibility or to assign responsibility to a third party for issuing Certificates of group Health Plan Coverage to Members who end coverage with Group.

At the request of Group and upon payment of the applicable fee by Group, Healthplan shall report Member enrollment dates and disenrollment dates to Group after open enrollment periods and upon termination of the Agreement. Alternatively, the Group may agree in writing to take primary responsibility for a third party for issue of Certificates of group health plan coverage to Members who end their coverage with the Group.

PAYMENT METHOD FOR GROUP

A. New Enrollment

1. If coverage begins on or before the fifteenth (15th) day of the month, a Prepayment Fee is due for that month.
2. If coverage begins on any other day of the month, no Prepayment Fee is due for that month.

B. Termination

1. If coverage ceases on or before the fifteenth (15th) day of the month, no Prepayment Fee is due for that month.
2. If coverage ceases on any other day of the month, a Prepayment Fee is due for that month.

SCHEDULE OF COPAYMENTS

The Schedule of Copayments designating the amounts charged to Members for receipt of covered services and benefits is attached hereto.

TERMINATION OF AGREEMENT

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

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

~~4.~~ Termination for Violation of Contribution or Participation Rules. We may terminate this Agreement upon sixty (60) days prior written notice to the Group if, after the initial twelve (12) month or other specified time period, it is determined that the Group is not in compliance with the participation and/or contribution requirements as established by us.

5. Termination Due to Association Membership Ceasing. If this Agreement covers an association, we may terminate this Agreement in accordance with applicable state or federal law as to a member of a bona fide association if the member is no longer a member of the bona fide association.

6. Termination in Accordance with State and/or Federal law. We may terminate this Agreement upon prior notice to the Group in accordance with any applicable state and/or federal law.

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

Notice of Termination to Members. If this Agreement is terminated for any reason in this section, we will notify you of the termination effective date. The Group will notify you of any applicable rights you may have under the "Continuation of Coverage" section.

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

AMENDMENT OR MODIFICATION OF AGREEMENT

1. Consent of Parties. The Agreement may be amended at any time through a subsequent written agreement between Group and Healthplan. Amendments are effective immediately unless otherwise provided.

2. Modification by Law or Regulation. The provisions of the Agreement are subject to the approval of all regulatory bodies and in the event that regulatory bodies request any modification of the Agreement, such modification shall supersede the provisions of the Agreement. Furthermore, any state or federal laws or regulations enacted or promulgated which are in conflict with the provisions of the Agreement shall be deemed modifications of the Agreement on the date such enactment or promulgation is applicable to this Agreement.

   Healthplan may modify the Prepayment Fees upon any change in state or federal laws affecting the Agreement by giving to Group at least thirty (30) days prior written notice.

3. Uniform Modification of Coverage. At renewal, the provisions of this Agreement may be modified to reflect product revisions which have uniformly been made to this product.

4. Modification by Notice From Healthplan. Healthplan may modify the provisions of the Agreement including any Prepayment Fees, Copayments and Supplemental Charges on any

Anniversary Date of Agreement by giving to Group at least two hundred ten (210) days prior written notice. Unless Group within ninety (90) days of receipt of such notice provides written notice to Healthplan of its intention to terminate this Agreement at the end of the term, the modification shall become effective on the date contained in the notice and shall apply to all Members whether or not the applicable Prepayment Fee has been paid.

NOTICE

Any written notice required under the Agreement shall be hand-delivered or mailed through the United States Postal Service, postage prepaid, addressed as follows:

To GROUP: Maricopa County

County Dept. of Material Management, Attention Director of Purchasing, 320 West Lincoln Street

Phoenix, Arizona 85003

Or, if Group elects to have notices delivered or mailed to a designated agent, such notices shall be deemed as having been received by Group if hand-delivered or mailed to the following person and address: N/A

To Healthplan: CIGNA HealthCare of Arizona, Inc. (Phoenix)
11001 No. Black Canyon Hwy, Suite 400
Phoenix, AZ 85029

To Member: To the latest address furnished by Group or by the Member to Healthplan.

AMENDMENTS, RIDERS AND ADDITIONAL PROVISIONS

Alternative Medicine Rider

This Face Sheet, the Group Service Agreement and the Contract for Services attached hereto shall constitute the entire agreement by and between the parties.

DISCRETIONARY CLAIM AUTHORITY

The Plan Administrator (Employer) hereby delegates to Healthplan the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but is not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator (Employer) also delegates to Healthplan the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

This language should be made a part of your Summary Plan Description.

ACCEPTANCE OF AGREEMENT

In witness whereof, the Parties enter into the CIGNA HEALTHCARE GROUP SERVICE AGREEMENT through the execution of this Face Sheet by their duly authorized representatives. In the event Group does not sign this Acceptance of Agreement section, Group's payment of any Prepayment Fees will be considered acceptance of the terms and conditions of this Agreement.

Healthplan: CIGNA HealthCare of Arizona, Inc.

By: _____

Title: Jeff U. Terrill, General Manager

Date: **8/23/2002**

Group: **Maricopa County**

Address: County Department of Material Management, Attn. Director of Purchasing, 320 West Phoenix, Arizona 85003

_____

By: _____

Title: _____

Date: _____

MARICOPA COUNTY

NON STANDARD BENEFITS

External Prosthetic Appliances(EPA) 100%, no deductible, $1,000 maximum

Short-Term Rehabilitation - $10 copay/Chiropractic Services - $10 copay

Alternative Medicine - $5 copay
6 visits per contract year without referral to approved provider
Southwest Naturopathic Medicine Center
Naturopathic Family Care

Benefits Include:
Physical Exam and Management
Physical Medicine
Acupuncture/Accupressure
Homeopathic Consultation
Biofeedback/Guided Imagery
Herbal and Homeopathic products as prescribed in conjunction with office visit and subsequently dispensed at designated Alternative Medicine Center not to exceed $60 retail value for all products per benefit year.

Standard model hearing aides are covered

Children on Missionary covered until 25 – Letter required from Church

45 day deferral on premium payment each month

90 day retro termination

Skilled Nursing Facility – 90 day maximum

Payment method based on 26 pay periods

CIGNA HEALTHCARE OF ARIZONA, INC. HANDBOOK

AND GROUP SERVICE AGREEMENT

Your Guide to Your Plan's Benefits

MARICOPA COUNTY

HMO Plan

Employee Name

Employee Address Line 1

Employee Address Line 2

Employee Address City, State ZIP

Welcome to CIGNA HealthCare!

Here is your guide to getting the most from your health care plan. It outlines the important benefits of belonging to a CIGNA HealthCare plan, tells you how to use those benefits wisely and should answer most of your questions. Please keep it for reference.

If you can't find the information that you need, call Member Services at the toll-free number on your CIGNA HealthCare ID card. Or visit our web site, www.cigna.com/healthcare.

When you have questions about anything, just call. We're here to help!

Table of Contents

FACE SHEET **1**

TO THE **1**

CIGNA HEALTHCARE GROUP SERVICE AGREEMENT **1**

WHICH IS INCORPORATED HEREIN BY REFERENCE **1**

AGREEMENT NUMBER: ( ) HMO 1
PARTIES TO AGREEMENT: .....
HEALTHPLAN: ..... CIGNA HEALTHCARE OF ARIZONA, INC. (PHOENIX) 1
GROUP: MARICOPA COUNTY 1
PREPAYMENT FEES AND GRACE PERIOD 1
ENROLLMENT 1
GROUP'S ENROLLMENT/ELIGIBILITY RULES 2
DISENROLLMENT 2
CERTIFICATION OF COVERAGE 2
PAYMENT METHOD FOR GROUP 11
A. New Enrollment 11
B. Termination 11
SCHEDULE OF COPAYMENTS 11
TERMINATION OF AGREEMENT 11
AMENDMENT OR MODIFICATION OF AGREEMENT 4
NOTICE 5
AMENDMENTS, RIDERS AND ADDITIONAL PROVISIONS 5
DISCRETIONARY CLAIM AUTHORITY 5

SECTION I. DEFINITIONS OF TERMS USED IN THIS GROUP SERVICE AGREEMENT **4**

AGREEMENT 5
ANNIVERSARY DATE OF AGREEMENT 5
CONTRACT YEAR 5
COPAYMENT 5
DAYS 5
DEPENDENT 5
EMERGENCY SERVICES 5
ENROLLMENT APPLICATION 5
FACE SHEET 5
GROUP 5
HEALTHPLAN 5
HEALTHPLAN MEDICAL DIRECTOR 6
MEDICAL SERVICES 6
MEDICALLY NECESSARY/MEDICAL NECESSITY 6
MEMBER 6
MEMBERSHIP UNIT 6
OPEN ENROLLMENT PERIOD 6
OTHER PARTICIPATING HEALTH CARE FACILITY 6
OTHER PARTICIPATING HEALTH PROFESSIONAL 6
PARTICIPATING HOSPITAL 7
PARTICIPATING PHYSICIAN 7
PARTICIPATING PROVIDER 7
PHYSICIAN 7
PREPAYMENT FEE 7

PRIMARY CARE PHYSICIAN (PCP) 7
PRIMARY PLAN 7
PRIOR AUTHORIZATION 7
REFERRAL 7
RIDER 7
SERVICE AREA 8
SERVICES AND SUPPLIES 8
SUBSCRIBER 8
TOTAL COPAYMENT MAXIMUMS 8
URGENT CARE 8
WE/US/OUR 8
YOU/YOUR 8

SECTION II. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE 8

WHO CAN ENROLL AS A MEMBER 8
A. To be eligible to enroll as a Subscriber, you must: 8
B. To be eligible to enroll as a Dependent, you must: 8
A. Enrollment during an Open Enrollment Period 9
B. Enrollment after an Open Enrollment Period 9
C. Special Enrollment After Open Enrollment Period 11
D. Enrollment Due to Loss of Prior Creditable Coverage 11
E. Full and Accurate Completion of Enrollment Application 11
F. Hospitalization on the Effective Date of Coverage 11

SECTION III. AGREEMENT PROVISIONS 12

A. Healthplan's Representations and Disclosures 12
B. Member’s Rights, Roles and Representations 16

SECTION IV. COVERED SERVICES AND SUPPLIES 26

PHYSICIAN SERVICES 26
INPATIENT HOSPITAL SERVICES 26
OUTPATIENT FACILITY SERVICES 27
EMERGENCY SERVICES AND URGENT CARE 27
AMBULANCE SERVICE 28
BREAST RECONSTRUCTION AND BREAST PROSTHESES 28
CANCER CLINICAL TRIALS 28
DIABETIC SERVICE AND SUPPLIES 30
DURABLE MEDICAL EQUIPMENT 430
ERECTILE DYSFUNCTION 431
EXTERNAL PROSTHETIC APPLIANCES 441
FAMILY PLANNING SERVICES (CONTRACEPTION AND VOLUNTARY STERILIZATION) 442
HOME HEALTH SERVICES 452
HOSPICE SERVICES 453
INFERTILITY 464
INPATIENT SERVICES AT OTHER PARTICIPATING HEALTH CARE FACILITIES 464
INTERNAL PROSTHETIC/MEDICAL APPLIANCES 464
LABORATORY AND RADIOLOGY SERVICES 464
MATERNITY CARE SERVICES 464
SUBSTANCE ABUSE SERVICES 475
Substance Abuse Detoxification Services 475
Excluded Substance Abuse Services 35
MEDICAL FOODS 35
NUTRITIONAL EVALUATION 486
OBSTETRICAL AND GYNECOLOGICAL SERVICES 486
ORGAN TRANSPLANT SERVICES 486

ORGAN TRANSPLANT TRAVEL SERVICES 487
OXYGEN 497
SHORT-TERM REHABILITATIVE THERAPY 498
CHIROPRACTIC CARE SERVICES 508
VISION AND HEARING SCREENINGS 509

SECTION V. EXCLUSIONS AND LIMITATIONS 509

EXCLUSIONS 509
LIMITATIONS 42

SECTION VI. OTHER SOURCES OF PAYMENT FOR SERVICES AND SUPPLIES 42

COORDINATION OF BENEFITS 43
A. Definitions 43
B. Order of Benefit Determination Rules 44
C. Effect on the Benefits of this Agreement. 45
D. Recovery of Excess Benefits 45
E. Right to Receive and Release Information 46

SECTION VII. TERMINATION OF YOUR COVERAGE 47

TERMINATION BY REASON OF INELIGIBILITY 47
TERMINATION BY TERMINATION OF THIS AGREEMENT 47
CERTIFICATION OF COVERAGE UPON TERMINATION 48

SECTION VIII. CONTINUATION OF COVERAGE 48

CONTINUATION OF GROUP COVERAGE UNDER COBRA 48
CONVERSION TO NON-GROUP (INDIVIDUAL) COVERAGE 50
A. Conversion After Loss of Subscriber Eligibility 50
B. Conversion Upon Death or Divorce of Subscriber 51
C. Conversion Upon Meeting Age Limitation 51
D. Conversion After Expiration of COBRA Continuation Coverage 51
CONTINUATION OF COVERAGE UNDER FMLA 51

SECTION IX. MISCELLANEOUS 52

ADDITIONAL PROGRAMS 52
ADMINISTRATIVE POLICIES RELATING TO THIS AGREEMENT 52
CLERICAL ERROR 52
ENTIRE AGREEMENT 52
NO IMPLIED WAIVER 53
NOTICE 53
RECORDS 53
SEVERABILITY 562
SUCCESSORS AND ASSIGNS 562
SERVICE MARKS 562

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 at the time that certain covered Service and Supplies are delivered. You are responsible for paying the Copayment at the time services are received.

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.

Group

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

Healthplan

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

Healthplan Medical Director

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

Medical Services

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

Medically Necessary/Medical Necessity

Medically necessary covered Service and Supplies are those Service and Supplies that are determined by the Healthplan Medical Director to be:

- No more than required to meet your essential health needs; and
- consistent with the diagnosis of the condition for which they are required; and
- consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; and
- required for purposes other than the comfort and convenience of the Provider or the comfort and convenience of the patient; and
- rendered in the least intensive setting that is appropriate for the delivery of health care

Member

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

Membership Unit

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

Open Enrollment Period

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

Other Participating Health Care Facility

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

Other Participating Health Professional

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

Participating Hospital

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

Participating Physician

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

Participating Provider

Participating Providers are Participating Hospitals, Participating Physicians, Other Participating Health Professionals, and other participating health care facilities.

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 Service 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 Service and Supplies to be covered under this Agreement.

Referral

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

Rider

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

Service Area

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

Services and Supplies

Those medically necessary Service and Supplies described in “Section IV Covered Services and Supplies."

Subscriber

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

Total Copayment Maximums

The total amount of Copayments that an individual Member or Membership unit must pay within a Contract Year. When the individual Member or Membership unit has paid applicable Copayments up to the

Total Copayment maximums, that Member or Membership unit will not be required to pay Copayments for the remainder of the Contract Year. It is the Subscriber's responsibility to maintain a record of Copayments which have been paid and to inform the Healthplan when the amount reaches the Total Copayment maximums. The Total Copayment maximums and the Copayments that apply toward these maximums are identified in the Schedule of Copayments.

Urgent Care

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

We/Us/Our

CIGNA HealthCare of Arizona, Inc.

You/Your

The Subscriber and/or any of his Dependents.

SECTION II. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Who Can Enroll as a Member

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

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

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

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

1. be the legal spouse of the Subscriber; or
2. be the natural child, step-child, or adopted child of the Subscriber; or the child for whom the Subscriber is the legal guardian, legally placed with the Subscriber for adoption, or supported pursuant to a court order imposed on the Subscriber (including a qualified medical child support order), provided that the child:
   a. is unmarried and legally dependent upon the Subscriber for support; and
      i. has not yet reached age nineteen (19); or
      ii. if the child is a full-time registered student in regular attendance at an accredited secondary school or an accredited college or university or church missionary, has not yet reached age twenty-five (25). If the school is located outside the Service Area, he is still eligible to enroll and will be covered for Emergency Services and Urgent Care benefits while at school; or
      iii. the child is nineteen (19) or older and continuously incapable of self-sustaining support because of mental retardation or a physical handicap which existed prior to attaining nineteen (19) 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) and (ii) above. We may, from time to time during the next two (2) years, require proof of the continuation of the child's condition and dependence. Thereafter, we may require such proof only once a year.

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

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

C. 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), your next opportunity to enroll will be during the next Open Enrollment Period.

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

   A newborn child who is born while this Agreement is being paid for at single or two-party rate shall have coverage effective as of the date of birth, if prior to the birth, the Subscriber submits to the Healthplan through the Group an enrollment application and pays the additional Prepayment Fees due. If these requirements are not met, the newborn child may be enrolled during the next designated Open Enrollment period.

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

Subscriber shall also submit to the Healthplan proof that the application and approval procedures for adoption pursuant to A.R.S. Section 8-105 or Section 8-108 have been completed.

A child who is legally adopted by or is placed with the Subscriber for adoption by or is place with the Subscriber for adoption while this Agreement is being paid for at a single or two-party rate shall have coverage effective as of the date the child is placed with the Subscriber if, within thirty-one (31) days after the date of placement, the Subscriber submits to the Healthplan through the Group an enrollment application and the Group pays any additional Prepayment Fees due. If the child is placed with the Subscriber before the adoption process is completed, the Subscriber shall also submit to the Healthplan proof that the application and approval procedures for adoption pursuant to A.R.S. Section 8-105 or section 8-108 have been completed. If these requirements are not met but the adoption is later completed, the adopted child may be enrolled during the designated Open Enrollment Period. If the adoption process is not completed and coverage has been provided to a child under this Agreement, the Subscriber shall pay the Healthplan for all services and benefits provided to the child at prevailing rates for staff model services and at the contracted rates for other services.

C. Special Enrollment After Open Enrollment Period

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

After the Open Enrollment Period, you may submit an Enrollment Application and any applicable fees, to the Group, for yourself and any eligible Dependent(s) within thirty-one (31) days of the date of the following events and comply with all other requirements set forth above in “Section B.” Enrollment after an Open Enrollment Period:

1. Marriage;
2. Birth of a dependent newborn child; or
3. Adoption of a dependent child or legal placement of a child for adoption.

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

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

D. Enrollment Due to Loss of Prior Creditable Coverage

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

1. are no longer eligible for the other coverage for any reason (including separation, divorce or death of the Subscriber);
2. lost the other coverage because of termination of the other plan’s coverage; or
3. completed continuation of other coverage as provided under federal or state law.

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

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

E. Full and Accurate Completion of Enrollment Application

Each Subscriber must fully and accurately complete the Enrollment Application. False, incomplete or misrepresented information 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.

F. Hospitalization on the Effective Date of Coverage

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

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

SECTION III. AGREEMENT PROVISIONS

A. Healthplan's Representations and Disclosures

1. The Healthplan is a for-profit health maintenance organization (HMO) which arranges for the provision of covered Service and Supplies through a network of Participating Providers. The list of Participating Providers is provided to all Members at enrollment. If you would like another list of Participating Providers, please contact Member Services at the toll-free number found on your CIGNA HealthCare ID card or visit the CIGNA HealthCare web site at www.cigna.com/healthcare.

2. With the exception of any employed Physicians who work in a facility operated by the Healthplan (so-called "staff model" providers), the Participating Providers are independent contractors. They are not the agents or employees of the Healthplan and they are not under the control of the Healthplan or any CIGNA company. All Participating Providers are required to exercise their independent medical judgment when providing care.

3. The Healthplan maintains all medical information concerning a Member as confidential in accordance with applicable laws and professional codes of ethics. A copy of the Healthplan’s confidentiality policy is available upon request.

4. We do not restrict communication between Participating Providers and Members regarding treatment options.

5. Under federal law (the Patient Self-Determination Act), you may execute advance directives, such as living wills or a durable power of attorney for health care, which permit you to state your wishes regarding your health care should you become incapacitated.

6. Upon your admission to a participating inpatient facility, a Participating Physician other than your PCP may be asked to direct and oversee your care for as long as you are in the inpatient facility. This Participating Physician is often referred to as an “inpatient manager” or “hospitalist.”

7. The terms of this Agreement may be changed in the future either as a result of an amendment agreed upon by the Healthplan and Group or to comply with changes in law. The Group or the Healthplan may terminate this Agreement as specified in this

Agreement. In addition, 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. If you do not select a PCP, we will assign one for you. If your PCP leaves the CIGNA HealthCare network, you will be able to choose a new PCP. You may voluntarily change your PCP for other reasons but not more than once in any calendar month. We reserve the right to determine the number of times during a Contract Year that you will be allowed to change your PCP. If you select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following your selection. If you select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example, if you notify us on June 10, the change will be 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 specialist may be limited to specialists in your PCP's medical group or network. Therefore, you may not have access to every specialist or Participating Provider in your Service Area. Before you select a PCP, you should check to see if that PCP is associated with the specialist or facility you prefer to use. If the Referral is not possible, you should ask the specialist or facility about which PCPs can make Referrals to them, and then verify the information with the PCP before making your selection.

9. **Referrals to Specialists**

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

Exceptions to the Referral process:

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

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

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

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

You may also visit a chiropractic Physician for covered services and supplies, as defined in "Section IV. Covered Services and Supplies", without a referral from your PCP.

Standing Referral to Specialist

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

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

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

Transition Care

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

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

1) You have a life threatening disease or condition, in which case the transitional period will not be more than thirty (30) days after the effective date of enrollment;
2) Entered the third trimester of pregnancy on the effective date of enrollment, in which case the transitional period includes the delivery and any care up to six weeks after the delivery that is related to the delivery

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

If you are a new Member whose health care provider is not a member of the Healthplan's network and you (i) are receiving an on-going course of treatment for a life-threatening disease or condition, or a degenerative or disabling disease or condition, or (ii) have

entered your second trimester or pregnancy as of the effective date of your enrollment, you may be eligible to receive continuity of care from that non-participating provider for a transitional period of up to sixty (60) days, or the post partum period directly related to the delivery of your child. Such continuity of care must be approved in advance by the Healthplan, and your doctor must agree to accept our reimbursement rate and to abide by the Healthplan policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider no longer participating in the Healthplan's network will not be available, such as when the provider loses his/her license to practice or retires.

10. **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 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).

B. Member's Rights, Roles and Representations

You have the right to:

1. Medical treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
2. Get the information you need about your health care plan, including information about services that are covered, services that are not covered, and any costs that you will be responsible for paying.
3. Have access to a current list of providers in our network and have access to information about a particular provider's education, training and practice.
4. Select a Primary Care Physician (PCP) for yourself and each covered Member of your family, and to change your PCP for any reason.
5. Have your medical information kept confidential by our employees and your health care provider. Confidentiality laws and professional rules of behavior allow us to release medical information only when it's required for your care, required by law, necessary for the administration of your plan or to support our programs or operations that evaluate quality and service. We may also summarize information in reports that do not identify you or any other participants specifically.
6. Have your health care provider give you information about your medical condition and your treatment options, regardless of benefit coverage or cost. You have the right to receive this information in terms you understand.
7. Learn about any care you receive. You should be asked for your consent to all care unless there is an emergency and your life and health are in serious danger.
8. Refuse medical care. If you refuse medical care, your health care provider should tell you what might happen. We urge you to discuss your concerns about care with your PCP. 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.

Your role is to:

1. Review and understand the information you receive about your health care plan. Please call CIGNA HealthCare Member Services when you have questions or concerns.
2. Understand how to obtain covered Service and Supplies that are provided under your plan.
3. Show your CIGNA HealthCare ID card before you receive care.
4. Schedule a new patient appointment with any new CIGNA HealthCare PCP; build a comfortable relationship with your doctor; ask questions about things you don't understand; and follow your doctor's advice. You should also understand that your condition may not improve and may even get worse if you don't follow your doctor's advice.
5. Provide honest, complete information to the providers caring for you.
6. Know what medicine you take, why, and how to take it.
7. Pay all Copayments for which you are responsible at the time the service is received.
8. Keep scheduled appointments and notify the doctor's office ahead of time if you are going to be late or miss an appointment.

9. Pay all charges for missed appointments and for services that are not covered by your plan.

10. Voice your opinions, concerns or complaints to CIGNA HealthCare Member Services and/or your provider.

11. 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 Service 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 Service 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.

C. When You Have a Complaint or an Appeal

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

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

Start with Member Services

We're here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call us at our toll-free number and explain your concern to one of our Customer Services representatives. You can also express that concern in writing. Please call or write to us at the following:

CIGNA HealthCare of Arizona, Inc.
P.O. Box 42005

Phoenix, AZ 85080-2002
Customer Services Toll-Free Number that appears on your CIGNA HealthCare ID card or Benefit Identification card

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

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

Appeals Procedure

HEALTHPLAN has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing at the address shown above within two (2) years of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by calling the toll-free number on your CIGNA HealthCare ID card or Benefit Identification card.

Level One Appeal

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

Within five (5) business days after receiving your request for review, the Healthplan will mail you and your Primary Care Physician ("PCP") or treating Provider a notice indicating that your request was received, and a copy of the Appeal Packet (sent to PCP or treating Provider upon request). For level one appeals, we will respond in writing with a decision within fifteen (15) calendar days after we receive an appeal for a pre-service or concurrent coverage determination, and within thirty (30) calendar days after we receive an appeal for a post-service coverage determination. If more time or information is needed to make the pre-service or concurrent determination, we will notify you in writing to request an extension of up to fifteen calendar days and to specify any additional information needed to complete the review. You may request that the appeal process be expedited if, your PCP or treating Provider certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient hospital stay. When an appeal is expedited, we will respond orally and in writing with a decision within the lesser of one (1) business day or seventy-two (72) hours.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal. Please send your review request relating to denial of a requested service that has not already been provided within 365 days of the last denial. Your review requests relating to payment of a service already provided should be sent within two (2) years of the last denial. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim.

Most requests for a second review will be conducted by the Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving Medical Necessity or clinical appropriateness the committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by the Healthplan Medical Director. You may present your situation to the committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request within 5 business days after receiving your request and schedule a committee review. For pre-service and concurrent care coverage determinations the committee review will be completed within fifteen (15) calendar days and for post-service claims, the committee review and written notification of the Appeals Committee's decision will be completed within thirty (30) calendar days. If more time or information is needed to make the pre-service or concurrent determination, we will notify you in writing to request an extension of up to fifteen (15) calendar days and to specify any additional information needed by the Appeals Committee to complete the review. You may request that the appeal process be expedited if, your PCP or treating Provider certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient hospital stay. When an appeal is expedited, we will respond orally with a decision within seventy-two (72) hours, followed up in writing.

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

External Independent Review

1. Eligibility

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

2. Deadlines Applicable to the Standard External Independent Review Process

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

a. Medical Necessity Issues

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

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

- mail a written notice to you, your PCP or treating provider, and the Director of the Arizona Department of Insurance ("Director of Insurance") of your request for External Independent Review, and

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

(2) Within 5 days of receiving our information, the Insurance Director must send all submitted information to an external independent review organization (the "IRO").

(3) Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

(4) Within 5 business days of receiving the IRO's decision, The Insurance Director must mail a notice of the decision to us, you, and your treating provider. If the IRO decides that the Healthplan should provide the service or pay the claim, the Healthplan must then authorize the service or pay the claim. If the IRO agrees with the Healthplan's decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

b. Coverage Issues

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

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

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

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

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

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

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

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

3. Deadlines Applicable to the Expedited External Independent Review Process

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

a. Medical Necessity Issues

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

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

- mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and
- forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of the Healthplan's decision, the criteria used and the clinical reasons for the decision, relevant portions of the Healthplan's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.

(2) Within 2 business days after the Director receives the information outlined above, the Director will choose an independent review organization (IRO) and forward to the organization all of the information received by the Director.

(3) Within 5 business days of receiving a case for Expedited External Independent Review from the Director, the IRO will evaluate and analyze the case and based on all the information received, render a decision and send the decision to the Director. Within 1 business day after receiving a notice of the decision from the IRO, the Director will mail a notice of the decision to you, your PCP or treating provider, and the Healthplan.

b. Coverage Issues

If your appeal for Expedited External Independent Review involves a contract coverage issue:

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

- mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and
- forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of the Healthplan's decision, the criteria used and the clinical reasons for the decision, relevant portions of the Healthplan's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.

(2) Within 2 business days after receipt of all the information outlined above, the Director will determine if the service or claim is covered and mail a notice of the determination to you, your PCP or treating provider, and the Healthplan

(3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have 5 business days to make a decision and send it to the Director. The Director will have 1 business day after receiving the IRO's decision to send the decision to the Healthplan, you and your treating provider.

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

(5) If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If the Healthplan disagrees with the Director's final decision, the Healthplan may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision.

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

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

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

Attention: Appeals Supervisor
Notice of Intent to File Suit
CIGNA HealthCare of Arizona
11001 N. Black Canyon Highway
Phoenix, Arizona 85029

Receipt of Documents

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

Complaints to the Arizona Department of Insurance

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

Appeal to the State of Arizona

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

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and will include (items 3, 4, and 5 are only included for adverse determinations): (1) the specific reason or reasons for the determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and

free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

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

Relevant Information

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

Legal Action

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

SECTION IV. COVERED SERVICES AND SUPPLIES

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

Unless otherwise authorized in writing by the Healthplan Medical Director, covered Service 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," "Chiropractic Care Services," and "Urgent Care."**
- **Prior Authorization is obtained from the Healthplan Medical Director by the Participating Provider, for those services that require Prior Authorization. Services that require Prior Authorization include, but are not limited to, inpatient hospital services, inpatient services at any other participating healthcare facility, outpatient facility services, magnetic resonance imaging, non-emergency ambulance, and organ transplant services. Prior authorization for non-emergency ambulance services may be obtained from a Participating Provider that is treating the Member.**

Physician Services

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

Inpatient Hospital Services

Inpatient hospital services for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in an Other Participating Health Care Facility. Inpatient hospital services include semi-private room and board; care and services in an intensive care unit; drugs, medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; laboratory and radiology services and other diagnostic and therapeutic services; anesthesia and associated services; inhalation therapy; radiation therapy; and other services which are customarily provided in acute care hospitals.

Outpatient Facility Services

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

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, which are required for relief of acute pain, for the initial treatment of acute infection or 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 serious medical complications, loss of life or permanent impairment to bodily functions 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. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital on the UB92 claim form or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency. You are covered for at least a screening examination to determine whether an emergency exists. Care up and through stabilization for emergency situations is covered without prior authorization.

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 SM or your PCP for direction and authorization prior to receiving services.

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

to: dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that you should not travel due to any medical condition.

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

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

Ambulance Service

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

Breast Reconstruction and Breast Prostheses

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

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

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

Cancer Clinical Trials

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

1) The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in the State of Arizona, that is for the treatment, palliation or prevention of cancer in humans and in which the scientific study includes all of the following: (a) specific goals; (b) a rationale and background for the study; (c) criteria for patient selection; (d) specific directions for administering the therapy and monitoring patients; (e) definition of quantitative measures for determining treatment response; and (f) methods for documenting and treating adverse reactions.

2) The treatment is being provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial.

3) The treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following: (a) One of the National Institutes of Health; (b) A National Institutes of Health Cooperative Group or Center; (c) The United States Food and Drug Administration in the form of an investigational new drug application; (d) The United States Department of Defense; (e) The United States Department of Veteran Affairs; (f) a qualified research entity that meets the criteria established by the National Institutes of Health for grant

eligibility; or (g) a panel of qualified recognized experts in clinical research within academic health institutions in the State of Arizona.

4) The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in the State of Arizona.

5) The personnel providing the treatment or conducting the study (a) are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise; (b) agree to accept reimbursement as payment in full from the Healthplan at the rates that are established by the Healthplan and that are not more than the level of reimbursement applicable to other similar services provided by the health care providers with the Healthplan's network.

6) There is no clearly superior, non-investigational treatment alternative.

7) The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as any non-investigational alternative.

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

1) "**Cooperative Group**" – means a formal network of facilities that collaborates on research projects and that has an established national institutes of health approved peer review program operating within the group, including the National Cancer Institute Clinical Cooperative Group and The National Cancer Institute Community Clinical Oncology Program.

2) "**Institutional Review Board**" – means any board, committee or other group that is both: (a) formally designated by an institution to approve the initiation of and to conduct periodic review of biomedical research involving human subjects and in which the primary purpose of such review is to assure the protection of the rights and welfare of the human subjects and not to review a clinical trial for scientific merit; and (b) approved by the National Institutes of Health Office for Protection From Research Risks.

3) "**Multiple Project Assurance Contract**" – means a contract between an institution and the United States Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and that sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

4) "**Patient Cost**" – means any fee or expense that is covered under the Evidence of Coverage and that is for a service or treatment that would be required if the patient were receiving usual and customary care. Patient Cost does not include the cost: (a) of any drug or device provided in a phase I cancer clinical trial; (b) of any investigational drug or device; (c) of non-health services that might be required for a person to receive treatment or intervention; (d) of managing the research of the clinical trial; (e) that would not be covered under the Member's contract; and (f) of treatment or services provided outside the State of Arizona.

Cosmetic Surgery

Reconstructive surgery or therapy to repair or correct a severe facial disfigurement or severe physical deformity (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 including, but not limited to microtia, amastia and Poland Syndrome.

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.

Diabetic Service and Supplies

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

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.

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, 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, custom bedroom equipment, non-power mattress, pillows, posturepedic mattresses, low air loss mattresses (powered), alternating pressure mattresses.
- Bath related items: bath lift, non-portable whirlpool, bathtub mats, toilet rails, raised toilet seats, bath benches, bath stools, hand held shower, paraffin baths, bath mats.
- Chairs, Lifts and Standing Devices: computerized or gyroscopic mobility systems, roll about chairs, geri chairs, hop chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two person transfer), vitrecomty chairs, auto tilt chairs and fixtures to real property (ceiling lifts, wheelchair ramps, automobile lifts – customizations).
- Air quality items: room humidifiers, vaporizers, air purifiers, electrostatic machines
- Blood/injection related items: blood pressure cuffs, centrifuges, nova pens, needle-less injectors
- Pumps: back packs for portable pumps
- Other equipment: heat lap, heating pad, cryounits, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adapters, enuresis alarms, magnetic equipment, scales (baby and adult), star gliders, elevators, saunas, exercise equipment, diathermy machines.

Erectile Dysfunction

Medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered when you have an established medical condition that clearly causes erectile dysfunction, such as post-operative prostatectomy and diabetes. Psychogenic erectile dysfunction does not warrant coverage for penile implants.

External Prosthetic Appliances

The initial purchase and fitting of external prosthetic devices ordered or prescribed by a participating physician which are used as a replacement or substitute for a missing body part and are necessary for the alleviation or correction of illness, injury or congenital defect.

External prosthetic appliances shall include:

- Basic limb prosthetics;
- Terminal devices such as a hand or hook;
- Braces and splints
- Non-foot orthoses – only the following non-foot orthoses are covered:
  - Rigid and semi-rigid custom fabricated orthoses,
  - Semi-rigid pre-fabricated and flexible orthoses; and
  - Rigid pre-fabricated orthoses including preparation, fitting and basic additions, such as bars and joints
- Custom foot orthotics – custom foot orthotics are only covered as follows:
  - For members with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease).
  - When the foot orthotic is an integral part of a leg brace and it is necessary for the proper functioning of the brace
  - When the foot orthotic 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
  - 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:

- External power enhancements or power controls for prosthetic limbs and terminal devices;
- Orthotic shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers; and
- Orthoses primarily used for cosmetic rather than functional reasons.

Coverage for replacement and repair of external prosthetic appliances is provided <u>only</u> when required due to reasonable wear and tear and/ anatomical change. All maintenance and repairs that result from Member's misuse are the Member's responsibility.

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).

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 and cost-effective setting. If you are a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), home health services will only be provided for you during times when there is a family member or care giver present in the home to meet your non-skilled care needs.

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

Hospice Services

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

Hospice care services do not include the following:

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

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

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

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

Infertility

Services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include approved surgical and medical treatment programs that have been established to have a reasonable likelihood of resulting in pregnancy.

The following are specifically excluded infertility services:

- Infertility drugs;
- In vitro fertilization; 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);
- Reversal of voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Cryopreservation of donor sperm and eggs; and
- Any experimental or investigational infertility procedures or therapies.

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 are permanent or temporary internal aids and supports for non-functional body parts, including testicular implants following medically necessary surgical removal of the testicles. Medically necessary repair, maintenance or replacement of a covered appliance is covered.

Laboratory and Radiology Services

Radiation therapy and other diagnostic and therapeutic radiological procedures.

Mammograms

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

Maternity Care Services

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

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

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

Substance Abuse Services

Substance abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of substance abuse.

Substance Abuse Detoxification Services

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

Excluded Substance Abuse Services

The following are specifically excluded from substance abuse services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this Agreement;
- Counseling for occupational problems.
- Residential care
- Custodial care.

Medical Foods

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

We will cover up to 50% of the cost of medical foods prescribed to treat inherited metabolic disorders covered under this contract. There is a maximum annual limit for medical foods of $5,000 which applies to the cost of all prescribed modified low protein foods and metabolic formula.

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

1. "Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program as prescribed by Arizona statute.
2. "Medical Foods" means modified low protein foods and metabolic formula.
3. "Metabolic Formula" mean foods that are of the following: (a) formulated to be consumed or administered enterally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (d) essential to a person's optimal growth, health and metabolic homeostasis.
4. "Modified Low Protein Foods" means foods that are all of the following: (a) formulated to be consumed or administered enternally under the supervision of a medical doctor or doctor of

osteopathy; (b) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; (d) essential to a person's optimal growth, health and metabolic homeostasis.

Nutritional Evaluation

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

Obstetrical and Gynecological Services

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

Organ Transplant Services

Human organ and tissue transplant services at designated facilities throughout the United States. This coverage is subject to the following conditions and limitations.

Organ transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ 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 small bowel/liver.

All organ transplant services other than cornea, kidney and autologous bone marrow/stem cell transplants must be received at a qualified or provisional CIGNA Lifesource Organ 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.

Organ Transplant Travel Services

Travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Organ 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 Organ Transplant Network® facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the Member receiving the transplant will include charges for:

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

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

The following are specifically excluded travel expenses:

- travel costs incurred due to travel within 60 miles of your home;
- laundry bills;
- telephone bills;
- alcohol or tobacco products; and
- charges for transportation that exceed coach class rates.
- These benefits are only available when the Member is the recipient of an organ transplant. No benefits are available where the Member is a donor.

Oxygen

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

Periodic Health Examinations

Periodic Health Examinations, include vision and hearing screenings provided by Primary Care Physician and are available on a least the following schedule:

Age 0-1 year	1 exam every four months
Age 2-5 years	1 exam every year
Age 6-40 years	1 exam every 5 years
Age 41-50 years	1 exam every 3 years
Age 51-60 years	1 exam every 2 years
Age 61 and over	1 exam every year

Additionally, Periodic Health Examinations are available to each Member within twelve (12) months after their coverage is effective.

Short-term Rehabilitative Therapy

Short-term rehabilitative therapy is part of a rehabilitation program, including physical, speech, occupational, cognitive, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Also included are services that are provided by a chiropractic Physician when provided on an outpatient setting. Services of a chiropractic Physician include the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

Services provided on an outpatient basis are subject to the maximum as shown in the "Outpatient Short Term Rehabilitative Therapy and Chiropractic Care Services" section of the Schedule of Copayments. The following limitations apply to short-term rehabilitative therapy and chiropractic care services:

* These services are not covered when they are considered custodial or educational in nature.
* Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living.
* Speech therapy is not covered when (a) used to improve speech skills that have not fully developed except when speech is not fully developed in children (under age 19) due to an underlying disease of malformation that prevented speech development; (b) intended to maintain speech communication; or (c) not restorative in nature.

If multiple outpatient services are provided on the same day they constitute one visit, but a separate Copayment will apply to the services provided by each Participating Provider.

Chiropractic Care Services

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

The following are specifically excluded from chiropractic care services:

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

Vision and Hearing Screenings

Vision and hearing screenings provided by your PCP are made available to you as described in the "Periodic Health Examinations" schedule in this section.

SECTION V. EXCLUSIONS AND LIMITATIONS

Exclusions

Any Service 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 Service 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 schools 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. 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.
5. 5.Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other custodial or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
6. Any Service and Supplies which are 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 approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia

(The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;

- the subject of review or approval by an Institutional Review Board for the proposed use;
    - the subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight (except as set forth in the "Cancer Clinical Trials" provision of "Section IV. Covered Services and Supplies"; or
    - not demonstrated, through existing peer-reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

7. Cosmetic surgery or surgical procedures primarily for the purpose of altering appearance, except for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, the eyelids, face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of portion of the body, including, the breast, face, lips, jaw, chin, nose, ears or genital; hair transplantation; chemical face peels or abrasion of the skin; electrolysis diplation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function, or surgery, which is medically necessary.

8. Orthognatic treatment/surgery, treatment/surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. However, medically necessary treatment of TMJ disorder is covered.

9. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered. 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.

10. Medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index parameters of the National Heart, Lung and Blood Institute guidelines is covered if the services are demonstrated through peer-review medical literature and scientifically based guidelines to be safe and effective for treatment of the condition.

11. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.

12. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."

13. Infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.

14. Reversal of voluntary sterilization procedures.

15. Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

16. Treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.

17. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.

18. Non-medical ancillary services including, but not limited to vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, work hardening, driving safety and services, training, educational therapy, or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.

19. Therapy to improve general physical condition including, routine, long term or nonmedically necessary chiropractic care and rehabilitative services which are provided to reduce potential risk factors where significant therapeutic improvement is not expected.

20. 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.

21. Private hospital rooms and/or private duty nursing unless determined to be medically necessary by the Healthplan Medical Director.

22. 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.

23. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, orthotics, elastic stockings, garter belts, corsets, dentures and wigs, except as provided in the “Diabetic Services and Supplies” provision of the “Covered Service and Supplies” section of the Agreement..

24. Eyeglass lenses and frames and contact lenses (except for the first pair of contacts for treatment of keratoconus or post-cataract surgery);

25. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

26. Treatment by acupuncture. All non-injectable prescription drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies.”

27. Routine foot care, including the paring and removing of corns and calluses or trimming of nails unless medically necessary.

28. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

29. Amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless medically necessary to determine the existence of a gender-linked genetic disorder.

30. Genetic testing and therapy including germ line and somatic unless determined medically necessary by the Healthplan Medical Director for the purpose of making treatment decisions.

31. 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.

32. Blood administration for the purpose of general improvement in physical condition.

33. Cost of biologicals that are medications for purposes of travel, or to protect against occupational hazards and risks. Cost of immunizations for purposes of travel or to protect against occupational hazards and risks unless Medically Necessary or indicated.

34. Cosmetics, dietary supplements, nutritional formulae (except for treatment of malabsorption syndromes), and health and beauty aids.

35. Expenses incurred for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.

36. Cosmetics, dietary supplements, health and beauty aids and nutritional formulae. However, nutritional formulae is covered when required for:

- The treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism); or
- Enteral feeding for which nutritional formulae (a) under state or federal law can be dispensed only through a physician's prescription and (b) is medically necessary as the primary source of nutrition.

In addition to the provisions of this "Exclusions and Limitations" section, you will be responsible for payments on a fee-for-service basis for Service 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 service or supplies, taking into account the impact of the event.

SECTION VI. OTHER SOURCES OF PAYMENT FOR SERVICES AND SUPPLIES

Workers' Compensation

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

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

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

Medicare Benefits

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

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

Coordination of Benefits

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

A. Definitions

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

Plan

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

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

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

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

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

Claim Determination Period

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

Reasonable Cash Value

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

B. Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

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

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

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

C. Effect on the Benefits of this Agreement.

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

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

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

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

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

E. Right to Receive and Release Information.

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

F. Injuries Covered under Med Pay Insurance

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

Statutory Liens

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

SECTION VII. TERMINATION OF YOUR COVERAGE

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

Termination By Reason of Ineligibility

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

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

Termination By Termination of This Agreement

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

1. Termination for Non-Payment of Fees. We may terminate this Agreement for the Group's non-payment of any Prepayment Fees owed to us.
2. Termination on Notice. The Group, without cause, may terminate this Agreement upon sixty (60) days prior written notice to us. We, without cause, may terminate this Agreement upon either: (i) ninety (90) days prior written notice to the Group of our decision to discontinue offering this particular type of coverage; or (ii) at the renewal date of the plan upon, one hundred eighty (180) days prior written notice to the Group of our decision to discontinue offering all coverage in the applicable market. If coverage is terminated in accordance with (i) above, the Group may purchase a type of coverage currently being offered in that market.
3. Termination for Fraud or Misrepresentation. We may terminate this Agreement upon thirty (30) days prior written notice to the Group if, at any time, we determine that the Group has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact.
4. Termination for Violation of Contribution or Participation Rules. We may terminate this Agreement upon sixty (60) days prior written notice to the Group if, after the initial twelve (12) month or other specified time period, it is determined that the Group is not in compliance with the participation and/or contribution requirements as established by us.
5. Termination Due to Association Membership Ceasing. If this Agreement covers an association, we may terminate this Agreement in accordance with applicable state or federal law as to a member of a bona fide association if the member is no longer a member of the bona fide association.

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

Notice of Termination to Members. If this Agreement is terminated for any reason in this section, we will notify you of the termination effective date. The Group will notify you of any applicable rights you may have under the "Continuation of Coverage" section.

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

Certification of Coverage Upon Termination

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

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

SECTION VIII. CONTINUATION OF COVERAGE

Continuation of Group Coverage under COBRA

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

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

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

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

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

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

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

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

The Subscriber or eligible Dependent may be required to pay a premium to continue coverage. If the Subscriber or eligible Dependent elects to continue coverage, the Subscriber or eligible Dependent will have 45 days from the date of election to pay the initial premium due. All subsequent premiums will be

due on a monthly basis. There is a 30 day grace period to pay premiums. If the premium is not paid before the expiration of the grace period, COBRA continuation benefits will end.

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

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

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

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

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

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

For all other qualifying events, the maximum period is 36 months, except as provided below.

If the employer provides continuation options in addition to COBRA, the Subscriber or eligible Dependent may elect one of them in lieu of COBRA, but the Subscriber or eligible Dependent may not have both. The election of another continuation option is a waiver of COBRA.

However, if the Plan provides for continuation of existing coverage for a certain period of time after any qualifying event, the Subscriber may receive a COBRA election form when the existing coverage actually ends. The Subscriber or eligible Dependent may elect COBRA continuation coverage for the balance of the 18, 29 or 36 month period.

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

- the date the employer ceases to provide any group health plan to any employee;
- the date the Subscriber or eligible Dependent fails to timely pay any required premium payment;
- the first day after the date of election on which the qualified beneficiary first becomes covered under any other group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition for such person; or the date such exclusion or limitation no longer applies to the Subscriber or Dependent;
- the first day after the date of election on which the qualified beneficiary first becomes entitled to Medicare (except for a Chapter 11 Bankruptcy qualifying event); or

- with respect to a qualified beneficiary whose coverage is being extended for the additional 11 months as described above, coverage will terminate on the first day of the month that is more than 30 days after the date in which the disabled individual is no longer disabled for Social Security purposes.

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

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

Conversion to Non-Group (Individual) Coverage

If you do not elect COBRA continuation coverage, fail to properly elect COBRA continuation coverage, are ineligible to elect COBRA continuation coverage, or had COBRA continuation coverage for which the maximum coverage period has expired, you may apply to the Healthplan for conversion to non-group (individual) coverage. You must continue to reside in the Service Area in order to be eligible for non-group (individual) coverage. You may apply for non-group (individual) coverage as follows:

A. Conversion After Loss of Subscriber Eligibility

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

B. Conversion Upon Death or Divorce of Subscriber

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

C. Conversion Upon Meeting Age Limitation

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

D. Conversion After Expiration of COBRA Continuation Coverage

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

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

Continuation of Coverage Under FMLA

If the Group is subject to the requirements of FMLA (the federal law known as 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.

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. Contact the Healthplan Member Services for a list of currently available programs, participating businesses, and other details regarding such arrangements. These programs may include discounts on the following types of services:

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

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

Administrative Policies Relating to this Agreement

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

Clerical Error

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

Entire Agreement

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

No Implied Waiver

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

Notice

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

Records

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

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 SM and CIGNA Lifesource Organ Transplant Network® are registered service marks of CIGNA Corporation.

PLAN MODIFICATION, AMENDMENT AND TERMINATION:

The employer as plan sponsor has the right, at any time, to change or terminate benefits under the plan, to change or terminate the eligibility of classes of employees to be covered by the plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. The procedure by which the eligibility of classes of employees may be changed or terminated, by which benefits may be changed or terminated, or by which part or the whole plan may be terminated, is contained in the employer's plan document, which is available for inspection and copying from the plan administrator designated by the employer. No consent of any participant is required to terminate, modify, amend, or change the plan.

Termination of the plan together with termination of the Agreement which funds the plan benefits will have no adverse effect on any benefits to be paid under the Agreement for any covered medical expenses incurred prior to the date that Agreement terminates. Likewise, any extension of benefits under the Agreement due to you or your dependent’s total disability that began prior to and has continued beyond the date the Agreement terminates, will not be affected by the plan termination. Rights to purchase limited amounts of medical insurance to replace part of the benefits lost because the Agreement terminated may arise under the terms of the Agreement. A subsequent plan termination will not affect the extension of benefits and rights under the Agreement, if any.

Your individual coverage terminates (a) when you leave your employment, (b) when you are no longer eligible, (c) if the plan is contributory, when you cease to contribute, (d) when the plan terminates, or (e) when the Agreement terminates, whichever happens first.

Note: If you cease active work, see your supervisor to determine what arrangements, if any, may be made to continue your coverage beyond the date you cease active work.

Funding

The plan is funded by contributions from the employer's general assets after any required contribution is obtained from employee payroll deduction.

Salary Reduction

You may elect to reduce your compensation during a plan year in such amount as is required to cover the amount of any required contribution toward the cost of the plan. The amount of the salary reduction agreed to shall be adjusted automatically in the event of a change in such cost during the plan year.

Duration of Election.

Your election to participate in the plan through salary reduction shall continue for so long as you remain eligible to participate unless revoked by you. You may not revoke your election to participate in the plan through salary reduction after the commencement of any plan year except as provided in the section, change in family status, without the effect of making all salary reduction amounts during that plan year includable in your gross taxable income.

Change in Family Status.

If you (in the judgment of the administrator) have a change in family status during a plan year, you may revoke your election to participate in the plan through salary reduction for the balance of the plan year and make a new election (i.e., change the salary reduction amount), but only if both the revocation and the new election are on account of and consistent with a change in family status. A change in family status for this purpose includes: marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse and such other events which the plan administrator determines will constitute a change in family status under the regulations and rulings of the Internal Revenue Service. Any new election will be effective at such terms as the plan administrator determines.

Alternative Medicine Services – Supplemental Rider

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

Alternative Medicine Services Benefit

I. Definitions

a. **Alternative Medicine Services** means services, treatments or products not performed, practiced or provided within the practice of standard medicine.

b. **Designated Alternative Medicine Center** means a facility or Physician qualified to provide certain Alternative Medicine Services who is designated by the HEALTHPLAN Medical Director to provide those services.

II. Services and Benefits

Coverage will be provided for certain outpatient Alternative Medicine Services received from a Designated Alternative Medicine Center or Other Participating Health Professional which are considered to be appropriate and preferable options to standard medical intervention. Coverage will also be provided for herbal or homeopathic products available at or through a Designated Alternative Medicine Center. Services for a member may be authorized by a Participating Physician, or the member may obtain the services from a Designated Alternative Medicine Center without authorization for up to six (6) visits per Contract Year.

a. Outpatient Alternative Medical Services

Covered Services include only the following services: Physician assessment, acupuncture, acupressure, physical medicine, guided imagery, massage therapy, biofeedback, and such other services as may be specifically approved by the HEALTHPLAN Medical Director.

b. **Herbal and Homeopathic Products**. Herbal and homeopathic products which are approved by the HEALTHPLAN are covered when obtained at the Designated Alternative Medicine Center. The retail cost of these products is subject to a Contract Year maximum of $60.00

Coverage under this Rider shall be subject to the following Copayments:

Office Visit	$5.00 Copayment per Visit
Herbal or Homeopathic Products	No charge

III. Exclusions

Except as otherwise set forth in this Rider, coverage is subject to the exclusions and limitations set froth in the 'Exclusions and Limitations" Section of the Agreement.

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

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

Covered Services and Supplies	***Copayments***
Physician Services	
Primary Care Physician Office Visit	$10 Copayment per office visit.
Preventive Care Adult Medical Care Periodic Physical Evaluation for Adults Well-Child Care Routine Immunizations and Injections Surgery Performed in the Physician's Office	The office visit Copayment will be waived when immunization is the only service provided
Specialty Care Physician Ofiice Visit	$10 Copayment per office visit
Office Visits Consultant and Referral Physcian Services Surgery Performed in the Physician's Office	

Covered Services and Supplies	*Copayments*
Inpatient Hospital Services 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	No charge
Outpatient Facility Services 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	No charge
Emergency and Urgent Care Services	
Physician's Office	Same as Physician's Office Visit
Hospital Emergency Room or Outpatient Facility	$75 Copayment per visit The emergency room Copayment will be waived if you are admitted to a participating hospital directly from the emergency room
Urgent Care Facility	$35 Copayment per visit
Ambulance Services	No Charge
Diabetic Services and Supplies	
Equipment	same as DME Copayment per item
Insulin and other Diabetic Pharmaceutical Supplies	$10 copayment per item /prescription
Durable Medical Equipment $3,500 maximum per member per contract year	No charge

Covered Services and Supplies	*Copayments*
External Prosthetic Appliances $1,000 maximum per member contract year	No Charge
Family Planning Services	
Office Visits (Tests, Counseling)	Same as Physician Office Visit Copayment;
Surgical Sterilization Procedures	Same as Inpatient Hospital, Outpatient Facility or Physician Office Visit Copayment, depending on facility used;
Home Health Services	No Charge
Hospice Services	
Inpatient Services	No Charge
Outpatient Services	No Charge
Infertility Services	
Physician Office Visit	$20 Copayment
Surgical Treatment	50% Copayment per procedure
Inpatient Services at Other Participating Health Care Facilities 90 days maximum per member per contract year	
Rehabilitation Hospital	No Charge
Skilled Nursing Facility and Sub-Acute Facilities	No Charge
Laboratory and Radiology Services	
MRIs, MRAs, CAT scans and PET scans	$50 Copayment
Other Laboratory and Radiology Services	No Charge

Covered Services and Supplies	*Copayments*
Mammograpy	Place of Service Copayment Applies
Maternity Care Services	
Initial Office Visit to Confirm Pregnancy	Same as Physician's Office Visit Copayment;
All other Office Visits	No Charge
Delivery	Same as Inpatient Hospital Copayment;
Inpatient Substance Abuse Detoxification Services	Same as Inpatient Hospital Copayment;
Outpatient Substance Abuse Detoxification Group Therapy	$10 Copayment per day
Organ Transplant Travel Services Maximum Maximum $10,000	
Short-term Rehabilitative Therapy 60 visit maximum per Member per Contract Year;	$10 Copayment per office visit
Self-Referred Chiropractic and Osteopathic Care Services 20 - visit maximum per Member per Contract Year	$10 Copayment per office visit

Total Copayment Maximum *		
Individual Member Total Copayment Maximum		$1,000 per Contract Year
Membership Unit Total Copayment Maximum		$2,000 per Contract Year

*Only Copayments identified in this Schedule of Copayments which have been paid by a Member for Inpatient Hospital, Outpatient Hospital Facility Services and Inpatient Services at Other Participating Health Care Facilities apply to these maximums

Maricopa County (Exhibit A)

Implementation Calendar

Effective Date: 01.01.03

Task	Responsible	Start Date	Target Completion Date	Actual Completion Date
Introduce Implementation Team to Maricopa County; discuss benefits, reporting, structure, billing, eligibility, pre- and post-enrollment materials, claim forms, ID cards and claim requirements	CIGNA, Maricopa County	9/11/02	9/11/02	9/11/02
Confirm Maricopa County's approval of structure, benefit summary, sample bill, eligibility and overall implementation strategy as outlined in the Implementation Guide	CIGNA	9/12/02	9/25/02	
Meet with Eligibility Services to review automated eligibility tape requirements	Maricopa County, CIGNA	9/23/02	10/4/02	
Provide structure codes to Maricopa County for coding of enrollment forms	CIGNA	9/26/02	10/1/02	
Internal CIGNA Expert Team meeting to review account requirements	CIGNA	9/27/02	10/4/02	
Load account structure & benefits into CIGNA systems	CIGNA	10/4/02	11/1/02	
ID cards and claim forms ordered	CIGNA	9/26/02	10/4/02	
Open enrollment period for Maricopa County	Maricopa County, CIGNA	10/12/02	11/3/02	

Submit automated eligibility test tape	Maricopa County	11/5/02	11/5/02	
Process automated test tape and report results to client	CIGNA	11/6/02	11/12/02	
Submit automated eligibility production tape *	Maricopa County	12/5/02	12/5/02	
Collect and distribute enrollment forms to appropriate areas for manual eligibility loading* **(changes for COBRA & Retirees)**	Maricopa County, CIGNA	11/4/02	12/5/02	
Eligibility loaded into CED	CIGNA	12/6/02	12/18/02	
Release ID card production feed	CIGNA	12/18/02	12/18/02	
ID cards and post-enrollment collateral materials mailed	CIGNA	12/19/02	12/24/02	
Mail first bill	CIGNA	12/30/02	12/31/02	
Conduct wrap-up meeting regarding implementation	CIGNA, Maricopa County	1/30/03	1/31/03	

*Performance guarantee commitment and penalty amounts are subject to receipt of usable and complete eligibility information by the date listed.

The dates included in this Implementation Calendar are subject to change. If a change is necessary, CIGNA will work with you to reach a new agreement that reflects the changes in circumstances.

The term "CIGNA" refers to the various entities, which will provide the coverage and/or services described, including, but not limited to, Connecticut General Life Insurance Company, CIGNA HealthCare, CIGNA Dental Health, Intracorp, and CIGNA Behavioral Health.

EXHIBIT B 01178-RFP POS
CIGNA HEALTHCARE OF ARIZONA, INC.

d/b/a CIGNA PRIVATE PRACTICE PLAN OF ARIZONA

Face Sheet

to the

CIGNA HEALTHCARE GROUP SERVICE AGREEMENT

which is incorporated herein by reference.

AGREEMENT NUMBER: (3205496) POS

PARTIES TO AGREEMENT:

HEALTHPLAN: CIGNA HealthCare of Arizona, Inc.

d/b/a CIGNA Private Practice Plan of Arizona

and

GROUP: Maricopa County

PREPAYMENT FEES AND GRACE PERIOD

On or before the last day of each month, Group shall remit to the Healthplan on behalf of each Subscriber and his Dependents the Prepayment Fee specified as follows in payment for services rendered under this Agreement in the following month. The Healthplan shall permit a grace period of forty-five (45) days during which the Prepayment Fees may be paid without loss of coverage under the Agreement. In the event this Agreement terminates and there are Prepayment Fees due to the Healthplan, the Group will be financially responsible for the Prepayment Fees. This responsibility will be in addition to any other financial obligation of the Group hereunder.

Group shall pay Prepayment Fees each month in the following amounts:

Membership Unit

Prepayment Fee

See Exhibit A

ENROLLMENT

The Healthplan is only required to consider enrollment applications received by the Healthplan (i) during the Open Enrollment Period or within sixty (60) days thereafter, or (ii) within sixty (60) days of the event creating eligibility. The Healthplan shall have the right, at reasonable times, to examine Group records,

including the payroll records of Subscribers for the purpose of confirming eligibility and appropriate Prepayment Fees under the Agreement.

An individual who did not enroll for coverage under the Agreement during the initial eligibility period or Open Enrollment Period may enroll for coverage in accordance with the “Enrollment after the Open Enrollment Period” provision in “Section II. Enrollment and Effective Date of Coverage” section.

GROUP'S ENROLLMENT/ELIGIBILITY RULES

Group’s enrollment and/or eligibility rules for its Subscribers and their Dependents are as follows:

New hires are eligible for coverage upon employers determination.

Full-time students covered until age 25

Children on church mission covered until age 25- Letter from church required

Coverage shall terminate on the last day of the pay period in which premium is paid or in which the employee ceases to be in a benefits eligible position.

Unless otherwise stated above, the eligibility provisions set forth in “Section II. Enrollment and Effective Date of Coverage” section of the Agreement will govern.

DISENROLLMENT

Group shall notify Healthplan of all employment terminations or other losses of eligibility of Subscribers and of losses of eligibility of Dependents ("Notice of Termination"). Unless otherwise required by law, coverage for the Subscribers and/or Dependents shall cease at midnight on the day the loss of eligibility occurs, and Group shall remit Prepayment Fees in accordance to the rules described under the section entitled "Payment Method for Group", through the date coverage ceased, subject to the following rules and exceptions:

1. Notice of Termination must be received by Healthplan within ninety (90) days of the date on which employment termination or loss of eligibility first occurred.
2. If Notice of Termination is not received by Healthplan within ninety (90) days of the date on which employment termination or loss of eligibility first occurred, then coverage shall cease at midnight on the date which is ninety (90) days prior to the date Notice of Termination is received and Group shall be responsible for and shall submit to Healthplan all Prepayment Fees due through the date coverage ceased.

CERTIFICATION OF COVERAGE

Healthplan shall issue Certificates of Group Health Plan Coverage to Members who end coverage with Group, provided that Group reports enrollment, disenrollment and other necessary information to Healthplan, according to transactions arranged between Healthplan and Group. Alternatively, Group may agree in writing to take primary responsibility or to assign responsibility to a third party for issuing Certificates of group Health Plan Coverage to Members who end coverage with Group.

At the request of Group and upon payment of the applicable fee by Group, Healthplan shall report Member enrollment dates and disenrollment dates to Group after open enrollment periods and upon termination of the Agreement. Alternatively, the Group may agree in writing to take primary responsibility for a third party for issue of Certificates of group health plan coverage to Members who end their coverage with the Group.

PAYMENT METHOD FOR GROUP

A. New Enrollment

1. If coverage begins on or before the fifteenth (15th) day of the month, a Prepayment Fee is due for that month.
2. If coverage begins on any other day of the month, no Prepayment Fee is due for that month.

B. Termination

1. If coverage ceases on or before the fifteenth (15th) day of the month, no Prepayment Fee is due for that month.
2. If coverage ceases on any other day of the month, a Prepayment Fee is due for that month.

SCHEDULE OF COPAYMENTS

The Schedule of Copayments designating the amounts charged to Members for receipt of covered services and benefits is attached hereto.

TERMINATION OF AGREEMENT

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

~~6.~~ Termination for Violation of Contribution or Participation Rules. We may terminate this Agreement upon sixty (60) days prior written notice to the Group if, after the initial twelve (12) month or other specified time period, it is determined that the Group is not in compliance with the participation and/or contribution requirements as established by us.

7. Termination Due to Association Membership Ceasing. If this Agreement covers an association, we may terminate this Agreement in accordance with applicable state or federal law as to a member of a bona fide association if the member is no longer a member of the bona fide association.

6. Termination in Accordance with State and/or Federal law. We may terminate this Agreement upon prior notice to the Group in accordance with any applicable state and/or federal law.

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

Notice of Termination to Members. If this Agreement is terminated for any reason in this section, we will notify you of the termination effective date. The Group will notify you of any applicable rights you may have under the "Continuation of Coverage" section.

Responsibility for Payment. The Group shall be responsible for the payment of all Prepayment Fees due through the date on which coverage ceases. You shall be financially responsible for all services rendered

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

AMENDMENT OR MODIFICATION OF AGREEMENT

1. Consent of Parties. The Agreement may be amended at any time through a subsequent written agreement between Group and Healthplan. Amendments are effective immediately unless otherwise provided.

2. Modification by Law or Regulation. The provisions of the Agreement are subject to the approval of all regulatory bodies and in the event that regulatory bodies request any modification of the Agreement, such modification shall supersede the provisions of the Agreement. Furthermore, any state or federal laws or regulations enacted or promulgated which are in conflict with the provisions of the Agreement shall be deemed modifications of the Agreement on the date such enactment or promulgation is applicable to this Agreement.

   Healthplan may modify the Prepayment Fees upon any change in state or federal laws affecting the Agreement by giving to Group at least thirty (30) days prior written notice.

3. Uniform Modification of Coverage. At renewal, the provisions of this Agreement may be modified to reflect product revisions which have uniformly been made to this product.

5. Modification by Notice From Healthplan. Healthplan may modify the provisions of the Agreement including any Prepayment Fees, Copayments and Supplemental Charges on any Anniversary Date of Agreement by giving to Group at least two hundred ten (210) days prior written notice. Unless Group within ninety (90) days of receipt of such notice provides written notice to Healthplan of its intention to terminate this Agreement at the end of the term, the modification shall become effective on the date contained in the notice and shall apply to all Members whether or not the applicable Prepayment Fee has been paid.

NOTICE

Any written notice required under the Agreement shall be hand-delivered or mailed through the United States Postal Service, postage prepaid, addressed as follows:

To GROUP: Maricopa County

County Dept. of Material Management, Attention Director of Purchasing, 320 West Lincoln Street

Phoenix, Arizona 85003

Or, if Group elects to have notices delivered or mailed to a designated agent, such notices shall be deemed as having been received by Group if hand-delivered or mailed to the following person and address: N/A

To Healthplan: CIGNA HealthCare of Arizona, Inc.
d/b/a CIGNA Private Practice Plan of Arizona
11001 No. Black Canyon Hwy, Suite 400
Phoenix, AZ 85029

To Member: To the latest address furnished by Group or by the Member to Healthplan.

AMENDMENTS, RIDERS AND ADDITIONAL PROVISIONS

Alternative Medicine Rider

This Face Sheet, the Group Service Agreement and the Contract for Services attached hereto shall constitute the entire agreement by and between the parties.

DISCRETIONARY CLAIM AUTHORITY

The Plan Administrator (Employer) hereby delegates to Healthplan the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but is not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator (Employer) also delegates to Healthplan the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

This language should be made a part of your Summary Plan Description.

ACCEPTANCE OF AGREEMENT

In witness whereof, the Parties enter into the CIGNA HEALTHCARE GROUP SERVICE AGREEMENT through the execution of this Face Sheet by their duly authorized representatives. In the event Group does not sign this Acceptance of Agreement section, Group's payment of any Prepayment Fees will be considered acceptance of the terms and conditions of this Agreement.

Healthplan: CIGNA HealthCare of Arizona, Inc. dba CIGNA Private Practice Plan of Arizona

By: _____

Title: Jeff U. Terrill, General Manager

Date: _____

Group: **Maricopa County**

Address: County Department of Material Management, Attn. Director of Purchasing, 320 West Phoenix, Arizona 85003

_____

By: _____

Title: _____

Date: _____

MARICOPA COUNTY

NON STANDARD BENEFITS

External Prosthetic Appliances(EPA) 100%, no deductible, $1,000 maximum

Short-Term Rehabilitation - $10 copay/Chiropractic Services - $10 copay

Alternative Medicine - $5 copay
6 visits per contract year without referral to approved provider
Southwest Naturopathic Medicine Center
Naturopathic Family Care

Benefits Include:
Physical Exam and Management
Physical Medicine
Acupuncture/Accupressure
Homeopathic Consultation
Biofeedback/Guided Imagery
Herbal and Homeopathic products as prescribed in conjunction with office visit and subsequently dispensed at designated Alternative Medicine Center not to exceed $60 retail value for all products per benefit year.

Standard model hearing aides are covered

Children on Missionary covered until 25 – Letter required from Church

45 day deferral on premium payment each month

90 day retro termination

Skilled Nursing Facility – 90 day maximum

Payment method based on 26 pay periods

CIGNA HEALTHCARE OF ARIZONA, INC. HANDBOOK AND GROUP SERVICE AGREEMENT

Your Guide to Your Plan's Benefits

MARICOPA COUNTY

Point of Service Plan

Employee Name

Employee Address Line 1

Employee Address Line 2

Employee Address City, State ZIP

Welcome to CIGNA HealthCare!

Here is your guide to getting the most from your health care plan. It outlines the important benefits of belonging to a CIGNA HealthCare plan, tells you how to use those benefits wisely and should answer most of your questions. Please keep it for reference.

If you can't find the information that you need, call Member Services at the toll-free number on your CIGNA HealthCare ID card. Or visit our web site, www.cigna.com/healthcare.

When you have questions about anything, just call. We're here to help!

Table of Contents

SECTION I. DEFINITIONS OF TERMS USED IN THIS GROUP SERVICE AGREEMENT 81

AGREEMENT 81
ANNIVERSARY DATE OF AGREEMENT 81
CONTRACT YEAR 81
COPAYMENT 81
DAYS 81
DEPENDENT 81
EMERGENCY SERVICES 82
ENROLLMENT APPLICATION 82
FACE SHEET 82
GROUP 82
HEALTHPLAN 82
HEALTHPLAN MEDICAL DIRECTOR 82
MEDICAL SERVICES 82
MEDICALLY NECESSARY/MEDICAL NECESSITY 82
MEMBER 82
MEMBERSHIP UNIT 82
OPEN ENROLLMENT PERIOD 83
OTHER PARTICIPATING HEALTH CARE FACILITY 83
OTHER PARTICIPATING HEALTH PROFESSIONAL 83
PARTICIPATING HOSPITAL 83
PARTICIPATING PHYSICIAN 83
PARTICIPATING PROVIDER 83
PHYSICIAN 83
PREPAYMENT FEE 83
PRIMARY CARE PHYSICIAN (PCP) 83
PRIMARY PLAN 83
PRIOR AUTHORIZATION 84
REFERRAL 84
RIDER 84
SERVICE AREA 84
SERVICES AND SUPPLIES 84
SUBSCRIBER 84
TOTAL COPAYMENT MAXIMUMS 84
URGENT CARE 84
WE/US/OUR 84
YOU/YOUR 84

SECTION II. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE 84

WHO CAN ENROLL AS A MEMBER 84
A. To be eligible to enroll as a Subscriber, you must: 84
B. To be eligible to enroll as a Dependent, you must: 85
A. Enrollment during an Open Enrollment Period 85
B. Enrollment after an Open Enrollment Period 85
C. Special Enrollment After Open Enrollment Period 86
D. Enrollment Due to Loss of Prior Creditable Coverage 87
E. Full and Accurate Completion of Enrollment Application 87
F. Hospitalization on the Effective Date of Coverage 87

SECTION III. AGREEMENT PROVISIONS 88

A. Healthplan's Representations and Disclosures 88
B. Member’s Rights, Roles and Representations 91
C. When You Have a Complaint or an Appeal 93

SECTION IV. COVERED SERVICES AND SUPPLIES 100

PHYSICIAN SERVICES 100
INPATIENT HOSPITAL SERVICES 100
OUTPATIENT FACILITY SERVICES 100
EMERGENCY SERVICES AND URGENT CARE 100
AMBULANCE SERVICE 102
BREAST RECONSTRUCTION AND BREAST PROSTHESES 102
CANCER CLINICAL TRIALS 102
DIABETIC SERVICE AND SUPPLIES 103
DURABLE MEDICAL EQUIPMENT 103
ERECTILE DYSFUNCTION 104
EXTERNAL PROSTHETIC APPLIANCES 104
FAMILY PLANNING SERVICES (CONTRACEPTION AND VOLUNTARY STERILIZATION) 105
HOME HEALTH SERVICES 105
HOSPICE SERVICES 106
INFERTILITY SERVCES 106
INPATIENT SERVICES AT OTHER PARTICIPATING HEALTH CARE FACILITIES 107
INTERNAL PROSTHETIC/MEDICAL APPLIANCES 107
LABORATORY AND RADIOLOGY SERVICES 107
MATERNITY CARE SERVICES 107
SUBSTANCE ABUSE SERVICES 107
Substance Abuse Detoxification Services 107
Excluded Substance Abuse Services 107
MEDICAL FOODS (THIS BENEFIT IS COVERED ONLY IF YOUR GROUP HAS PURCHASED PRESCRIPTION DRUG COVERAGE) 108
NUTRITIONAL EVALUATION 108
OBSTETRICAL AND GYNECOLOGICAL SERVICES 108
ORGAN TRANSPLANT SERVICES 109
ORGAN TRANSPLANT TRAVEL SERVICES 109
OXYGEN 109
SHORT-TERM REHABILITATIVE THERAPY 110
CHIROPRACTIC CARE SERVICES 110
VISION AND HEARING SCREENINGS 111

SECTION V. EXCLUSIONS AND LIMITATIONS 111

EXCLUSIONS 111
LIMITATIONS 113

SECTION VI. OTHER SOURCES OF PAYMENT FOR SERVICES AND SUPPLIES 114

COORDINATION OF BENEFITS 114
A. Definitions 114
B. Order of Benefit Determination Rules 115
C. Effect on the Benefits of this Agreement. 116
D. Recovery of Excess Benefits 116
E. Right to Receive and Release Information 117

SECTION VII. TERMINATION OF YOUR COVERAGE 119

TERMINATION BY REASON OF INELIGIBILITY 119
TERMINATION BY TERMINATION OF THIS AGREEMENT 119
CERTIFICATION OF COVERAGE UPON TERMINATION 120

SECTION VIII. CONTINUATION OF COVERAGE 120

CONTINUATION OF GROUP COVERAGE UNDER COBRA 120
CONVERSION TO NON-GROUP (INDIVIDUAL) COVERAGE 122
A. Conversion After Loss of Subscriber Eligibility 122

B. Conversion Upon Death or Divorce of Subscriber 122
C. Conversion Upon Meeting Age Limitation 122
D. Conversion After Expiration of COBRA Continuation Coverage 122
CONTINUATION OF COVERAGE UNDER FMLA 123

SECTION IX. MISCELLANEOUS 123

ADDITIONAL PROGRAMS 123
ADMINISTRATIVE POLICIES RELATING TO THIS AGREEMENT 123
CLERICAL ERROR 124
ENTIRE AGREEMENT 124
NO IMPLIED WAIVER 124
NOTICE 124
RECORDS 124
SEVERABILITY 124
SUCCESSORS AND ASSIGNS 124
SERVICE MARKS 124

ERISA SUMMARY PLAN DESCRIPTION ..... ERROR! BOOKMARK NOT DEFINED.

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 at the time that certain covered Service and Supplies are delivered. You are responsible for paying the Copayment at the time services are received.

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.

Group

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

Healthplan

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

Healthplan Medical Director

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

Medical Services

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

Medically Necessary/Medical Necessity

Medically necessary covered Service and Supplies are those Service and Supplies that are determined by the Healthplan Medical Director to be:

- No more than required to meet your essential health needs; and
- consistent with the diagnosis of the condition for which they are required; and
- consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; and
- required for purposes other than the comfort and convenience of the Provider or the comfort and convenience of the patient; and
- rendered in the least intensive setting that is appropriate for the delivery of health care

Member

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

Membership Unit

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

Open Enrollment Period

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

Other Participating Health Care Facility

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

Other Participating Health Professional

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

Participating Hospital

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

Participating Physician

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

Participating Provider

Participating Providers are Participating Hospitals, Participating Physicians, Other Participating Health Professionals, and other participating health care facilities.

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 Service 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 Service and Supplies to be covered under this Agreement.

Referral

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

Rider

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

Service Area

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

Services and Supplies

Those medically necessary Service and Supplies described in “Section IV Covered Services and Supplies."

Subscriber

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

Total Copayment Maximums

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

Urgent Care

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

We/Us/Our

CIGNA HealthCare of Arizona, Inc.

You/Your

The Subscriber and/or any of his Dependents.

SECTION II. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Who Can Enroll as a Member

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

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

1. be an employee of the Group or a participant in the Group; and

2. reside or work in the Service Area; and

3. meet and continue to meet these criteria.

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

1. be the legal spouse of the Subscriber; or

2. be the natural child, step-child, or adopted child of the Subscriber; or the child for whom the Subscriber is the legal guardian, legally placed with the Subscriber for adoption, or supported pursuant to a court order imposed on the Subscriber (including a qualified medical child support order), provided that the child:

   a. is unmarried and legally dependent upon the Subscriber for support; and

      i. has not yet reached age nineteen (19); or

      ii. if the child is a full-time registered student in regular attendance at an accredited secondary school or an accredited college or university or church missionary, has not yet reached age twenty-five (25). If the school is located outside the Service Area, he is still eligible to enroll and will be covered for Emergency Services and Urgent Care benefits while at school; or

      iv. the child is nineteen **(**19) or older and continuously incapable of self-sustaining support because of mental retardation or a physical handicap which existed prior to attaining nineteen (19) 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) and (ii) above. We may, from time to time during the next two (2) years, require proof of the continuation of the child's condition and dependence. Thereafter, we may require such proof only once a year.

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

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

C. 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), your next opportunity to enroll will be during the next Open Enrollment Period.

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

   A newborn child who is born while this Agreement is being paid for at single or two-party rate shall have coverage effective as of the date of birth, if prior to the birth, the Subscriber submits to the Healthplan through the Group an enrollment application and pays the additional Prepayment Fees due. If these requirements are not met, the newborn child may be enrolled during the next designated Open Enrollment period.

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

   A child who is legally adopted by or is placed with the Subscriber for adoption by or is place with the Subscriber for adoption while this Agreement is being paid for at a single or two-party rate shall have coverage effective as of the date the child is placed with the Subscriber if, within thirty-one (31) days after the date of placement, the Subscriber submits to the Healthplan through the Group an enrollment application and the Group pays any additional Prepayment Fees due. If the child is placed with the Subscriber before the adoption process is completed, the Subscriber shall also submit to the Healthplan proof that the application and approval procedures for adoption pursuant to A.R.S. Section 8-105 or section 8-108 have been completed. If these requirements are not met but the adoption is later completed, the adopted child may be enrolled during the designated Open Enrollment Period. If the adoption process is not completed and coverage has been provided to a child under this Agreement, the Subscriber shall pay the Healthplan for all services and benefits provided to the child at prevailing rates for staff model services and at the contracted rates for other services.

C. Special Enrollment After Open Enrollment Period

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

After the Open Enrollment Period, you may submit an Enrollment Application and any applicable fees, to the Group, for yourself and any eligible Dependent(s) within thirty-one (31) days of the date of the following events and comply with all other requirements set forth above in "Section B." Enrollment after an Open Enrollment Period:

1. Marriage;
2. Birth of a dependent newborn child; or
3. Adoption of a dependent child or legal placement of a child for adoption.

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

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

D. Enrollment Due to Loss of Prior Creditable Coverage

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

1. are no longer eligible for the other coverage for any reason (including separation, divorce or death of the Subscriber);
2. lost the other coverage because of termination of the other plan's coverage; or
3. completed continuation of other coverage as provided under federal or state law.

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

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

E. Full and Accurate Completion of Enrollment Application

Each Subscriber must fully and accurately complete the Enrollment Application. False, incomplete or misrepresented information 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.

F. Hospitalization on the Effective Date of Coverage

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

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

SECTION III. AGREEMENT PROVISIONS

A. Healthplan's Representations and Disclosures

1. The Healthplan is a for-profit health maintenance organization (HMO) which arranges for the provision of covered Service and Supplies through a network of Participating Providers. The list of Participating Providers is provided to all Members at enrollment. If you would like another list of Participating Providers, please contact Member Services at the toll-free number found on your CIGNA HealthCare ID card or visit the CIGNA HealthCare web site at www.cigna.com/healthcare.

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.

9. 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."

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

11. **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. If you do not select a PCP, we will assign one for you. If your PCP leaves the CIGNA HealthCare network, you will be able to choose a new PCP. You may voluntarily change your PCP for other reasons but not more than once in any calendar month. We reserve the right to determine the number of times during a Contract Year that you will be allowed to change your PCP. If you select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following your selection. If you select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example, if you notify us on June 10, the change will be 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 specialist may be limited to specialists in your PCP's medical group or network. Therefore, you may not have access to every specialist or Participating Provider in your Service Area. Before you select a PCP, you should check to see if that PCP is associated with the specialist or facility you prefer to use. If the

Referral is not possible, you should ask the specialist or facility about which PCPs can make Referrals to them, and then verify the information with the PCP before making your selection.

9. **Referrals to Specialists**

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

Exceptions to the Referral process:

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

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

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

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

You may also visit a chiropractic Physician for covered services and supplies, as defined in “Section IV. Covered Services and Supplies”, without a referral from your PCP.

Standing Referral to Specialist

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

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

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

Transition Care

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

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

1) You have a life threatening disease or condition, in which case the transitional period will not be more than thirty (30) days after the effective date of enrollment;

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

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

If you are a new Member whose health care provider is not a member of the Healthplan's network and you (i) are receiving an on-going course of treatment for a life-threatening disease or condition, or a degenerative or disabling disease or condition, or (ii) have entered your second trimester or pregnancy as of the effective date of your enrollment, you may be eligible to receive continuity of care from that non-participating provider for a transitional period of up to sixty (60) days, or the post partum period directly related to the delivery of your child. Such continuity of care must be approved in advance by the Healthplan, and your doctor must agree to accept our reimbursement rate and to abide by the Healthplan policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider no longer participating in the Healthplan's network will not be available, such as when the provider loses his/her license to practice or retires.

10. **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 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).

B. Member's Rights, Roles and Representations

You have the right to:

1. Medical treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
2. Get the information you need about your health care plan, including information about services that are covered, services that are not covered, and any costs that you will be responsible for paying.
3. Have access to a current list of providers in our network and have access to information about a particular provider's education, training and practice.
4. Select a Primary Care Physician (PCP) for yourself and each covered Member of your family, and to change your PCP for any reason.
5. Have your medical information kept confidential by our employees and your health care provider. Confidentiality laws and professional rules of behavior allow us to release medical information only when it's required for your care, required by law, necessary for the administration of your plan or to support our programs or operations that evaluate quality and service. We may also summarize information in reports that do not identify you or any other participants specifically.
6. Have your health care provider give you information about your medical condition and your treatment options, regardless of benefit coverage or cost. You have the right to receive this information in terms you understand.

7. Learn about any care you receive. You should be asked for your consent to all care unless there is an emergency and your life and health are in serious danger.
8. Refuse medical care. If you refuse medical care, your health care provider should tell you what might happen. We urge you to discuss your concerns about care with your PCP. 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.

Your role is to:

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

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

C. When You Have a Complaint or an Appeal

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

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

Start with Member Services

We’re here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call us at our toll-free number and explain your concern to one of our Customer Services representatives. You can also express that concern in writing. Please call or write to us at the following:

CIGNA HealthCare of Arizona, Inc.
P.O. Box 42005

Phoenix, AZ 85080-2002
Customer Services Toll-Free Number that appears on your CIGNA HealthCare ID card or Benefit Identification card

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

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

Appeals Procedure

HEALTHPLAN has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing at the address shown above within two (2) years of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to

write, you may ask to register your appeal by calling the toll-free number on your CIGNA HealthCare ID card or Benefit Identification card.

Level One Appeal

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

Within five (5) business days after receiving your request for review, the Healthplan will mail you and your Primary Care Physician ("PCP") or treating Provider a notice indicating that your request was received, and a copy of the Appeal Packet (sent to PCP or treating Provider upon request). For level one appeals, we will respond in writing with a decision within fifteen (15) calendar days after we receive an appeal for a pre-service or concurrent coverage determination, and within thirty (30) calendar days after we receive an appeal for a post-service coverage determination. If more time or information is needed to make the pre-service or concurrent determination, we will notify you in writing to request an extension of up to fifteen calendar days and to specify any additional information needed to complete the review. You may request that the appeal process be expedited if, your PCP or treating Provider certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient hospital stay. When an appeal is expedited, we will respond orally and in writing with a decision within the lesser of one (1) business day or seventy-two (72) hours.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal. Please send your review request relating to denial of a requested service that has not already been provided within 365 days of the last denial. Your review requests relating to payment of a service already provided should be sent within two (2) years of the last denial. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim.

Most requests for a second review will be conducted by the Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving Medical Necessity or clinical appropriateness the committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by the Healthplan Medical Director. You may present your situation to the committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request within 5 business days after receiving your request and schedule a committee review. For pre-service and concurrent care coverage determinations the committee review will be completed within fifteen (15) calendar days and for post-service claims, the committee review and written notification of the Appeals Committee's decision will be completed within thirty (30) calendar days. If more time or information is needed to make the pre-service or concurrent determination, we will notify you in writing to request an extension of up to fifteen (15) calendar days and to specify any additional information needed by the Appeals Committee to complete the review. You may request that the appeal process be expedited if, your PCP or treating Provider certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient hospital stay. When an appeal is expedited, we will respond orally with a decision within seventy-two (72) hours, followed up in writing.

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

External Independent Review

1. Eligibility

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

2. Deadlines Applicable to the Standard External Independent Review Process

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

a. Medical Necessity Issues

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

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

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

(2) Within 5 days of receiving our information, the Insurance Director must send all submitted information to an external independent review organization (the "IRO").

(3) Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

(4) Within 5 business days of receiving the IRO's decision, The Insurance Director must mail a notice of the decision to us, you, and your treating provider. If the IRO decides that the Healthplan should provide the service or pay the claim, the Healthplan must then authorize the service or pay the claim. If the IRO agrees with the Healthplan's decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

b. Coverage Issues

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

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

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

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

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

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

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

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

3. Deadlines Applicable to the Expedited External Independent Review Process

After receiving written notice from the Healthplan that your Expedited Level 2 Appeal has been denied, you have only 5 business days to submit a written request to the Healthplan for an Expedited External Independent Review. Your request should include any additional

material justification or documentation that you have not already sent to us to support your request for the service or payment of a claim.

a. Medical Necessity Issues

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

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

- mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and
- forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of the Healthplan's decision, the criteria used and the clinical reasons for the decision, relevant portions of the Healthplan's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.

(2) Within 2 business days after the Director receives the information outlined above, the Director will choose an independent review organization (IRO) and forward to the organization all of the information received by the Director.

(3) Within 5 business days of receiving a case for Expedited External Independent Review from the Director, the IRO will evaluate and analyze the case and based on all the information received, render a decision and send the decision to the Director. Within 1 business day after receiving a notice of the decision from the IRO, the Director will mail a notice of the decision to you, your PCP or treating provider, and the Healthplan.

b. Coverage Issues

If your appeal for Expedited External Independent Review involves a contract coverage issue:

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

- mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and

- forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of the Healthplan's decision, the criteria used and the clinical reasons for the decision, relevant portions of the Healthplan's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.

(2) Within 2 business days after receipt of all the information outlined above, the Director will determine if the service or claim is covered and mail a notice of the determination to you, your PCP or treating provider, and the Healthplan

(3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have 5 business days to make a decision and send it to the Director. The Director will have 1 business day after receiving the IRO's decision to send the decision to the Healthplan, you and your treating provider.

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

(5) If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If the Healthplan disagrees with the Director's final decision, the Healthplan may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision.

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

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

Notice will be considered provided by you on the date received by the Healthplan. The notice of intent to file suit must be sent to the

Healthplan via Certified Mail Return Receipt Request to the following address:

Attention: Appeals Supervisor
Notice of Intent to File Suit
CIGNA HealthCare of Arizona
11001 N. Black Canyon Highway
Phoenix, Arizona 85029

Receipt of Documents

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

Complaints to the Arizona Department of Insurance

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

Appeal to the State of Arizona

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

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and will include (items 3, 4, and 5 are only included for adverse determinations): (1) the specific reason or reasons for the determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

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

Relevant Information

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

Legal Action

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

SECTION IV. COVERED SERVICES AND SUPPLIES

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

Unless otherwise authorized in writing by the Healthplan Medical Director, covered Service 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," "Chiropractic Care Services," and "Urgent Care."**
- **Prior Authorization is obtained from the Healthplan Medical Director by the Participating Provider, for those services that require Prior Authorization. Services that require Prior Authorization include, but are not limited to, inpatient hospital services, inpatient services at any other participating healthcare facility, outpatient facility services, magnetic resonance imaging, non-emergency ambulance, and organ transplant services. Prior authorization for non-emergency ambulance services may be obtained from a Participating Provider that is treating the Member.**

Physician Services

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

Inpatient Hospital Services

Inpatient hospital services for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in an Other Participating Health Care Facility. Inpatient hospital services include semi-private room and board; care and services in an intensive care unit; drugs, medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; laboratory and radiology services and other diagnostic and therapeutic services; anesthesia and associated services; inhalation therapy; radiation therapy; and other services which are customarily provided in acute care hospitals.

Outpatient Facility Services

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

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, which are required for relief of acute pain, for the initial treatment of acute infection or 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 serious medical complications, loss of life or permanent impairment to bodily functions 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. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital on the UB92 claim form or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency. You are covered for at least a screening examination to determine whether an emergency exists. Care up and through stabilization for emergency situations is covered without prior authorization.

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 SM or your PCP for direction and authorization prior to receiving services.

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

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

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

Ambulance Service

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

Breast Reconstruction and Breast Prostheses

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

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

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

Cancer Clinical Trials

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

1) The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in the State of Arizona, that is for the treatment, palliation or prevention of cancer in humans and in which the scientific study includes all of the following: (a) specific goals; (b) a rationale and background for the study; (c) criteria for patient selection; (d) specific directions for administering the therapy and monitoring patients; (e) definition of quantitative measures for determining treatment response; and (f) methods for documenting and treating adverse reactions.

2) The treatment is being provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial.

3) The treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following: (a) One of the National Institutes of Health; (b) A National Institutes of Health Cooperative Group or Center; (c) The United States Food and Drug Administration in the form of an investigational new drug application; (d) The United States Department of Defense; (e) The United States Department of Veteran Affairs; (f) a qualified research entity that meets the criteria established by the National Institutes of Health for grant eligibility; or (g) a panel of qualified recognized experts in clinical research within academic health institutions in the State of Arizona.

4) The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in the State of Arizona.

5) The personnel providing the treatment or conducting the study (a) are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise; (b) agree to accept reimbursement as payment in full from the Healthplan at the rates that are established by the Healthplan and that are not more than the level of reimbursement applicable to other similar services provided by the health care providers with the Healthplan's network.

6) There is no clearly superior, non-investigational treatment alternative.

7) The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as any non-investigational alternative.

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

1) "**Cooperative Group**" – means a formal network of facilities that collaborates on research projects and that has an established national institutes of health approved peer review program operating within the group, including the National Cancer Institute Clinical Cooperative Group and The National Cancer Institute Community Clinical Oncology Program.

2) "**Institutional Review Board**" – means any board, committee or other group that is both: (a) formally designated by an institution to approve the initiation of and to conduct periodic review of biomedical research involving human subjects and in which the primary purpose of such review is to assure the protection of the rights and welfare of the human subjects and not to review a clinical trial for scientific merit; and (b) approved by the National Institutes of Health Office for Protection From Research Risks.

3) "**Multiple Project Assurance Contract**" – means a contract between an institution and the United States Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and that sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

4) "**Patient Cost**" – means any fee or expense that is covered under the Evidence of Coverage and that is for a service or treatment that would be required if the patient were receiving usual and customary care. Patient Cost does not include the cost: (a) of any drug or device provided in a phase I cancer clinical trial; (b) of any investigational drug or device; (c) of non-health services that might be required for a person to receive treatment or intervention; (d) of managing the research of the clinical trial; (e) that would not be covered under the Member's contract; and (f) of treatment or services provided outside the State of Arizona.

Cosmetic Surgery

Reconstructive surgery or therapy to repair or correct a severe facial disfigurement or severe physical deformity (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 including, but not limited to microtia, amastia and Poland Syndrome.

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.

Diabetic Service and Supplies

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

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.

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, 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, custom bedroom equipment, non-power mattress, pillows, posturepedic mattresses, low air loss mattresses (powered), alternating pressure mattresses.
- Bath related items: bath lift, non-portable whirlpool, bathtub mats, toilet rails, raised toilet seats, bath benches, bath stools, hand held shower, paraffin baths, bath mats.
- Chairs, Lifts and Standing Devices: computerized or gyroscopic mobility systems, roll about chairs, geri chairs, hop chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two person transfer), vitrecomty chairs, auto tilt chairs and fixtures to real property (ceiling lifts, wheelchair ramps, automobile lifts – customizations).
- Air quality items: room humidifiers, vaporizers, air purifiers, electrostatic machines
- Blood/injection related items: blood pressure cuffs, centrifuges, nova pens, needle-less injectors
- Pumps: back packs for portable pumps
- Other equipment: heat lap, heating pad, cryounits, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adapters, enuresis alarms, magnetic equipment, scales (baby and adult), star gliders, elevators, saunas, exercise equipment, diathermy machines.

Erectile Dysfunction

Medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered when you have an established medical condition that clearly causes erectile dysfunction, such as post-operative prostatectomy and diabetes. Psychogenic erectile dysfunction does not warrant coverage for penile implants.

External Prosthetic Appliances

The initial purchase and fitting of external prosthetic devices ordered or prescribed by a participating physician which are used as a replacement or substitute for a missing body part and are necessary for the alleviation or correction of illness, injury or congenital defect.

External prosthetic appliances shall include:

- Basic limb prosthetics;
- Terminal devices such as a hand or hook;
- Braces and splints
- Non-foot orthoses – only the following non-foot orthoses are covered:
  - Rigid and semi-rigid custom fabricated orthoses,
  - Semi-rigid pre-fabricated and flexible orthoses; and

- Rigid pre-fabricated orthoses including preparation, fitting and basic additions, such as bars and joints

- Custom foot orthotics – custom foot orthotics are only covered as follows:
  - For members with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease).
  - When the foot orthotic is an integral part of a leg brace and it is necessary for the proper functioning of the brace
  - When the foot orthotic 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
  - 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:

- External power enhancements or power controls for prosthetic limbs and terminal devices;
- Orthotic shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers; and
- Orthoses primarily used for cosmetic rather than functional reasons.

Coverage for replacement and repair of external prosthetic appliances is provided <u>only</u> when required due to reasonable wear and tear and/ anatomical change. All maintenance and repairs that result from Member's misuse are the Member's responsibility.

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).

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 and cost-effective setting. If you are a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), home health services will only be provided for you during times when there is a family member or care giver present in the home to meet your non-skilled care needs.

Home health services are those skilled health care services that can be provided during visits by Other Participating Health Professionals. The services of a home health aid are covered when rendered in direct support of skilled health care services provided by Other Participating Health Professional. A visit is defined as a period of 2 hours or less. Home Health services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other

Participating Health Professionals in providing home health services are covered. Home health services do not include services by a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house even if that person is an Other Participating Health Professional. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are subject to the benefit limitations described under Short-term Rehabilitative Therapy in the Schedule of Copayments.

Hospice Services

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

Hospice care services do not include the following:

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

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

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

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

Infertility

Services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include approved surgical and medical treatment programs that have been established to have a reasonable likelihood of resulting in pregnancy.

The following are specifically excluded infertility services:

- Infertility drugs;
- In vitro fertilization; 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);

- Reversal of voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Cryopreservation of donor sperm and eggs; and
- Any experimental or investigational infertility procedures or therapies.

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 are permanent or temporary internal aids and supports for non-functional body parts, including testicular implants following medically necessary surgical removal of the testicles. Medically necessary repair, maintenance or replacement of a covered appliance is covered.

Laboratory and Radiology Services

Radiation therapy and other diagnostic and therapeutic radiological procedures.

Mammograms

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

Maternity Care Services

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

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

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

Substance Abuse Services

Substance abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of substance abuse.

Substance Abuse Detoxification Services

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

Excluded Substance Abuse Services

The following are specifically excluded from substance abuse services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this Agreement;
- Counseling for occupational problems.
- Residential care
- Custodial care.

Medical Foods

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

We will cover up to 50% of the cost of medical foods prescribed to treat inherited metabolic disorders covered under this contract. There is a maximum annual limit for medical foods of $5,000 which applies to the cost of all prescribed modified low protein foods and metabolic formula.

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

5. "Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program as prescribed by Arizona statute.
6. "Medical Foods" means modified low protein foods and metabolic formula.
7. "Metabolic Formula" mean foods that are of the following: (a) formulated to be consumed or administered enterally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (d) essential to a person's optimal growth, health and metabolic homeostasis.
8. "Modified Low Protein Foods" means foods that are all of the following: (a) formulated to be consumed or administered enternally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; (d) essential to a person's optimal growth, health and metabolic homeostasis.

Nutritional Evaluation

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

Obstetrical and Gynecological Services

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

Organ Transplant Services

Human organ and tissue transplant services at designated facilities throughout the United States. This coverage is subject to the following conditions and limitations.

Organ transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ 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 small bowel/liver.

All organ transplant services other than cornea, kidney and autologous bone marrow/stem cell transplants must be received at a qualified or provisional CIGNA Lifesource Organ 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.

Organ Transplant Travel Services

Travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Organ 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 Organ Transplant Network® facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the Member receiving the transplant will include charges for:

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

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

The following are specifically excluded travel expenses:

- travel costs incurred due to travel within 60 miles of your home;
- laundry bills;
- telephone bills;
- alcohol or tobacco products; and
- charges for transportation that exceed coach class rates.
- These benefits are only available when the Member is the recipient of an organ transplant. No benefits are available where the Member is a donor.

Oxygen

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

Periodic Health Examinations

Periodic Health Examinations, include vision and hearing screenings provided by Primary Care Physician and are available on a least the following schedule:

Age 0-1 year	1 exam every four months
Age 2-5 years	1 exam every year
Age 6-40 years	1 exam every 5 years
Age 41-50 years	1 exam every 3 years
Age 51-60 years	1 exam every 2 years
Age 61 and over	1 exam every year

Additionally, Periodic Health Examinations are available to each Member within twelve (12) months after their coverage is effective.

Short-term Rehabilitative Therapy

Short-term rehabilitative therapy is part of a rehabilitation program, including physical, speech, occupational, cognitive, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Also included are services that are provided by a chiropractic Physician when provided on an outpatient setting. Services of a chiropractic Physician include the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

Services provided on an outpatient basis are subject to the maximum as shown in the "Outpatient Short Term Rehabilitative Therapy and Chiropractic Care Services" section of the Schedule of Copayments. The following limitations apply to short-term rehabilitative therapy and chiropractic care services:

* These services are not covered when they are considered custodial or educational in nature.
* Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living.
* Speech therapy is not covered when (a) used to improve speech skills that have not fully developed except when speech is not fully developed in children (under age 19) due to an underlying disease of malformation that prevented speech development; (b) intended to maintain speech communication; or (c) not restorative in nature.

If multiple outpatient services are provided on the same day they constitute one visit, but a separate Copayment will apply to the services provided by each Participating Provider.

Chiropractic Care Services

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

The following are specifically excluded from chiropractic care services:

- Services of a Chiropractor or Osteopath which are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting;

- Maintenance or preventive treatment consisting of routine, long term or non-medically necessary care provided to prevent reoccurrence or to maintain the patient's current status;
- Vitamin therapy.

Vision and Hearing Screenings

Vision and hearing screenings provided by your PCP are made available to you as described in the "Periodic Health Examinations" schedule in this section.

SECTION V. EXCLUSIONS AND LIMITATIONS

Exclusions

Any Service 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 Service and Supplies:

37. Care for health conditions that are required by state or local law to be treated in a public facility.

38. Care required by state or federal law to be supplied by a public schools system or school district.

39. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.

40. 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.

41. 5.Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other custodial or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

42. Any Service and Supplies which are 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 approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- the subject of review or approval by an Institutional Review Board for the proposed use;
    - the subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight (except as set forth in the "Cancer Clinical Trials" provision of "Section IV. Covered Services and Supplies"; or
    - not demonstrated, through existing peer-reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

43. Cosmetic surgery or surgical procedures primarily for the purpose of altering appearance, except for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, the eyelids, face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of portion of the body, including, the breast,

face, lips, jaw, chin, nose, ears or genital; hair transplantation; chemical face peels or abrasion of the skin; electrolysis diplation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function, or surgery, which is medically necessary.

44. Orthognatic treatment/surgery, treatment/surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. However, medically necessary treatment of TMJ disorder is covered.

45. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

46. Medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index parameters of the National Heart, Lung and Blood Institute guidelines is covered if the services are demonstrated through peer-review medical literature and scientifically based guidelines to be safe and effective for treatment of the condition.

47. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.

48. 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."

49. Infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.

50. Reversal of voluntary sterilization procedures.

51. Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

52. Treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.

53. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.

54. Non-medical ancillary services including, but not limited to vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, work hardening, driving safety and services, training, educational therapy, or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.

55. Therapy to improve general physical condition including, routine, long term or nonmedically necessary chiropractic care and rehabilitative services which are provided to reduce potential risk factors where significant therapeutic improvement is not expected.

56. 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.

57. Private hospital rooms and/or private duty nursing unless determined to be medically necessary by the Healthplan Medical Director.

58. 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.

59. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, orthotics, elastic stockings, garter belts, corsets, dentures and wigs, except as provided in the “Diabetic Services and Supplies” provision of the “Covered Service and Supplies” section of the Agreement..

60. Eyeglass lenses and frames and contact lenses (except for the first pair of contacts for treatment of keratoconus or post-cataract surgery);

61. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

62. Treatment by acupuncture. All non-injectable prescription drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies.”

63. Routine foot care, including the paring and removing of corns and calluses or trimming of nails unless medically necessary.

64. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

65. Amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless medically necessary to determine the existence of a gender-linked genetic disorder.

66. Genetic testing and therapy including germ line and somatic unless determined medically necessary by the Healthplan Medical Director for the purpose of making treatment decisions.

67. 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.

68. Blood administration for the purpose of general improvement in physical condition.

69. Cost of biologicals that are medications for purposes of travel, or to protect against occupational hazards and risks. Cost of immunizations for purposes of travel or to protect against occupational hazards and risks unless Medically Necessary or indicated.

70. Cosmetics, dietary supplements, nutritional formulae (except for treatment of malabsorption syndromes), and health and beauty aids.

71. Expenses incurred for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.

72. Cosmetics, dietary supplements, health and beauty aids and nutritional formulae. However, nutritional formulae is covered when required for:

    - The treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism); or
    - Enteral feeding for which nutritional formulae (a) under state or federal law can be dispensed only through a physician’s prescription and (b) is medically necessary as the primary source of nutrition.

In addition to the provisions of this "Exclusions and Limitations" section, you will be responsible for payments on a fee-for-service basis for Service 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 service or supplies, taking into account the impact of the event.

SECTION VI. OTHER SOURCES OF PAYMENT FOR SERVICES AND SUPPLIES

Workers' Compensation

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

3. Where the Healthplan has directly rendered or arranged for the rendering of services the Healthplan shall have a right to reimbursement to the extent of the Prevailing Rates for the care and treatment so rendered.

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

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

Medicare Benefits

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

Coordination of Benefits

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

A. Definitions

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

Plan

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

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

- Medical benefits coverage of group, group-type, and individual automobile contracts.

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

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

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

Claim Determination Period

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

Reasonable Cash Value

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

B. Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

1. The Plan that covers you as a Subscriber or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;

2. If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as a Subscriber or employee;

3. If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

    a. first, if a court decree states that one parent is responsible for the child's health care expenses or health coverage and the Plan for that parent has actual

knowledge of the terms of the order, but only from the time of actual knowledge;

b. Then, the Plan of the parent with custody of the child;

c. Then, the Plan of the spouse of the parent with custody of the child;

d. Then, the Plan of the parent not having custody of the child, and

e. Finally, the Plan of the spouse of the parent not having custody of the child.

4. The Plan that covers you as an active employee (or as that employee's dependent) shall be the Primary Plan and the Plan that covers you as a laid-off or retired employee (or as that employee's dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

5. The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

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

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

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

C. Effect on the Benefits of this Agreement.

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

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

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

1. Our obligation to provide Service 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 claims 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 Service and Supplies that should have been paid by the Primary Plan or if we provide services in excess of those for which we are obligated to provide under this Agreement,

we shall have the right to recover the actual payment made or the Reasonable Cash Value of any services.

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

E. Right to Receive and Release Information.

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

G. Injuries Covered under Med Pay Insurance

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

Statutory Liens

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

CIGNA HealthCare

SECTION VII. TERMINATION OF YOUR COVERAGE

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

Termination By Reason of Ineligibility

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

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

Termination By Termination of This Agreement

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

1. Termination for Non-Payment of Fees. We may terminate this Agreement for the Group's non-payment of any Prepayment Fees owed to us.
2. Termination on Notice. The Group, without cause, may terminate this Agreement upon sixty (60) days prior written notice to us. We, without cause, may terminate this Agreement upon either: (i) ninety (90) days prior written notice to the Group of our decision to discontinue offering this particular type of coverage; or (ii) at the renewal date of the plan upon, one hundred eighty (180) days prior written notice to the Group of our decision to discontinue offering all coverage in the applicable market. If coverage is terminated in accordance with (i) above, the Group may purchase a type of coverage currently being offered in that market.
3. Termination for Fraud or Misrepresentation. We may terminate this Agreement upon thirty (30) days prior written notice to the Group if, at any time, we determine that the Group has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact.
4. Termination for Violation of Contribution or Participation Rules. We may terminate this Agreement upon sixty (60) days prior written notice to the Group if, after the initial twelve (12) month or other specified time period, it is determined that the Group is not in compliance with the participation and/or contribution requirements as established by us.
5. Termination Due to Association Membership Ceasing. If this Agreement covers an association, we may terminate this Agreement in accordance with applicable state or federal law as to a member of a bona fide association if the member is no longer a member of the bona fide association.

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

Notice of Termination to Members. If this Agreement is terminated for any reason in this section, we will notify you of the termination effective date. The Group will notify you of any applicable rights you may have under the "Continuation of Coverage" section.

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

such date, the Group shall also be financially responsible for, and shall submit to us, all Prepayment Fees due until such date as the Group gives proper notice.

Certification of Coverage Upon Termination

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

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

SECTION VIII. CONTINUATION OF COVERAGE

Continuation of Group Coverage under COBRA

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For all other qualifying events, the maximum period is 36 months, except as provided below.

If the employer provides continuation options in addition to COBRA, the Subscriber or eligible Dependent may elect one of them in lieu of COBRA, but the Subscriber or eligible Dependent may not have both. The election of another continuation option is a waiver of COBRA.

However, if the Plan provides for continuation of existing coverage for a certain period of time after any qualifying event, the Subscriber may receive a COBRA election form when the existing coverage actually ends. The Subscriber or eligible Dependent may elect COBRA continuation coverage for the balance of the 18, 29 or 36 month period.

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

- the date the employer ceases to provide any group health plan to any employee;
- the date the Subscriber or eligible Dependent fails to timely pay any required premium payment;

- the first day after the date of election on which the qualified beneficiary first becomes covered under any other group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition for such person; or the date such exclusion or limitation no longer applies to the Subscriber or Dependent;
- the first day after the date of election on which the qualified beneficiary first becomes entitled to Medicare (except for a Chapter 11 Bankruptcy qualifying event); or
- with respect to a qualified beneficiary whose coverage is being extended for the additional 11 months as described above, coverage will terminate on the first day of the month that is more than 30 days after the date in which the disabled individual is no longer disabled for Social Security purposes.

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

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

Conversion to Non-Group (Individual) Coverage

If you do not elect COBRA continuation coverage, fail to properly elect COBRA continuation coverage, are ineligible to elect COBRA continuation coverage, or had COBRA continuation coverage for which the maximum coverage period has expired, you may apply to the Healthplan for conversion to non-group (individual) coverage. You must continue to reside in the Service Area in order to be eligible for non-group (individual) coverage. You may apply for non-group (individual) coverage as follows:

A. Conversion After Loss of Subscriber Eligibility

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

B. Conversion Upon Death or Divorce of Subscriber

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

C. Conversion Upon Meeting Age Limitation

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

D. Conversion After Expiration of COBRA Continuation Coverage

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

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

Continuation of Coverage Under FMLA

If the Group is subject to the requirements of FMLA (the federal law known as 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.

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. Contact the Healthplan Member Services for a list of currently available programs, participating businesses, and other details regarding such arrangements. These programs may include discounts on the following types of services:

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

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

Administrative Policies Relating to this Agreement

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

Clerical Error

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

Entire Agreement

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

No Implied Waiver

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

Notice

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

Records

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

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 SM and CIGNA Lifesource Organ Transplant Network® are registered service marks of CIGNA Corporation.

PLAN MODIFICATION, AMENDMENT AND TERMINATION:

The employer as plan sponsor has the right, at any time, to change or terminate benefits under the plan, to change or terminate the eligibility of classes of employees to be covered by the plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. The procedure by which the eligibility of classes of employees may be changed or terminated, by which benefits may be changed or terminated, or by which part or the whole plan may be terminated, is contained in the employer's plan

document, which is available for inspection and copying from the plan administrator designated by the employer. No consent of any participant is required to terminate, modify, amend, or change the plan.

Termination of the plan together with termination of the Agreement which funds the plan benefits will have no adverse effect on any benefits to be paid under the Agreement for any covered medical expenses incurred prior to the date that Agreement terminates. Likewise, any extension of benefits under the Agreement due to you or your dependent's total disability that began prior to and has continued beyond the date the Agreement terminates, will not be affected by the plan termination. Rights to purchase limited amounts of medical insurance to replace part of the benefits lost because the Agreement terminated may arise under the terms of the Agreement. A subsequent plan termination will not affect the extension of benefits and rights under the Agreement, if any.

Your individual coverage terminates (a) when you leave your employment, (b) when you are no longer eligible, (c) if the plan is contributory, when you cease to contribute, (d) when the plan terminates, or (e) when the Agreement terminates, whichever happens first.

Note: If you cease active work, see your supervisor to determine what arrangements, if any, may be made to continue your coverage beyond the date you cease active work.

Funding

The plan is funded by contributions from the employer's general assets after any required contribution is obtained from employee payroll deduction.

Salary Reduction

You may elect to reduce your compensation during a plan year in such amount as is required to cover the amount of any required contribution toward the cost of the plan. The amount of the salary reduction agreed to shall be adjusted automatically in the event of a change in such cost during the plan year.

Duration of Election.

Your election to participate in the plan through salary reduction shall continue for so long as you remain eligible to participate unless revoked by you. You may not revoke your election to participate in the plan through salary reduction after the commencement of any plan year except as provided in the section, change in family status, without the effect of making all salary reduction amounts during that plan year includable in your gross taxable income.

Change in Family Status.

If you (in the judgment of the administrator) have a change in family status during a plan year, you may revoke your election to participate in the plan through salary reduction for the balance of the plan year and make a new election (i.e., change the salary reduction amount), but only if both the revocation and the new election are on account of and consistent with a change in family status. A change in family status for this purpose includes: marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse and such other events which the plan administrator determines will constitute a change in family status under the regulations and rulings of the Internal Revenue Service. Any new election will be effective at such terms as the plan administrator determines.

Alternative Medicine Services – Supplemental Rider

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

CIGNA HealthCare

Alternative Medicine Services Benefit

IV. Definitions

c. **Alternative Medicine Services** means services, treatments or products not performed, practiced or provided within the practice of standard medicine.

d. **Designated Alternative Medicine Center** means a facility or Physician qualified to provide certain Alternative Medicine Services who is designated by the HEALTHPLAN Medical Director to provide those services.

V. Services and Benefits

Coverage will be provided for certain outpatient Alternative Medicine Services received from a Designated Alternative Medicine Center or Other Participating Health Professional which are considered to be appropriate and preferable options to standard medical intervention. Coverage will also be provided for herbal or homeopathic products available at or through a Designated Alternative Medicine Center. Services for a member may be authorized by a Participating Physician, or the member may obtain the services from a Designated Alternative Medicine Center without authorization for up to six (6) visits per Contract Year.

c. Outpatient Alternative Medical Services

Covered Services include only the following services: Physician assessment, acupuncture, acupressure, physical medicine, guided imagery, massage therapy, biofeedback, and such other services as may be specifically approved by the HEALTHPLAN Medical Director.

d. **Herbal and Homeopathic Products**. Herbal and homeopathic products which are approved by the HEALTHPLAN are covered when obtained at the Designated Alternative Medicine Center. The retail cost of these products is subject to a Contract Year maximum of $60.00

Coverage under this Rider shall be subject to the following Copayments:

Office Visit	$5.00 Copayment per Visit
Herbal or Homeopathic Products	No charge

VI. Exclusions

Except as otherwise set forth in this Rider, coverage is subject to the exclusions and limitations set froth in the ‘Exclusions and Limitations” Section of the Agreement.

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.

CIGNA HealthCare

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

Covered Services and Supplies	*Copayments*
Physician Services	
Primary Care Physician Office Visit Preventive Care Adult Medical Care Periodic Physical Evaluation for Adults Well-Child Care Routine Immunizations and Injections Surgery Performed in the Physician's Office	$15 Copayment per office visit. The office visit Copayment will be waived when immunization is the only service provided
Specialty Care Physician Ofiice Visit Office Visits Consultant and Referral Physcian Services Surgery Performed in the Physician's Office	$25 Copayment per office visit
Inpatient Hospital Services 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	$100 Copayment per admission
Outpatient Facility Services 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	$50 Copayment per facility use

CIGNA HealthCare

Covered Services and Supplies	*Copayments*
Emergency and Urgent Care Services	
Physician's Office	Same as Physician's Office Visit
Hospital Emergency Room or Outpatient Facility	$100 Copayment per visit The emergency room Copayment will be waived if you are admitted to a participating hospital directly from the emergency room
Urgent Care Facility	$50 Copayment per visit
Ambulance Services	No Charge
Diabetic Services and Supplies	
Equipment	same as DME Copayment per item
Insulin and other Diabetic Pharmaceutical Supplies	$10 copayment per item /prescription
Durable Medical Equipment $3,500 maximum per member per contract year	No charge
External Prosthetic Appliances $1,000 maximum per member contract year	No Charge
Family Planning Services	
Office Visits (Tests, Counseling)	Same as Physician Office Visit Copayment;
Surgical Sterilization Procedures	Same as Inpatient Hospital, Outpatient Facility or Physician Office Visit Copayment, depending on facility used;
Home Health Services	No Charge

CIGNA HealthCare

Covered Services and Supplies	*Copayments*
Hospice Services	
Inpatient Services	No Charge
Outpatient Services	No Charge
Infertility Services	
Physician Office Visit	Same as Physician's Office Visit Copayment;
Surgical Treatment	50% Copayment per procedure
Inpatient Services at Other Participating Health Care Facilities 90 days maximum per member per contract year	
Rehabilitation Hospital	No Charge
Skilled Nursing Facility and Sub-Acute Facilities	No Charge
Laboratory and Radiology Services	
MRIs, MRAs, CAT scans and PET scans	$50 Copayment
Other Laboratory and Radiology Services	No Charge
Mammograpy	Place of Service Copayment Applies
Maternity Care Services	
Initial Office Visit to Confirm Pregnancy	Same as Physician's Office Visit Copayment;
All other Office Visits	No Charge
Delivery	Same as Inpatient Hospital Copayment;

CIGNA HealthCare

Covered Services and Supplies	*Copayments*
Mental Health and Substance Abuse Services	
Inpatient Substance Abuse Detoxification Services	Same as Inpatient Hospital Copayment;
Outpatient Substance Abuse Detoxification Group Therapy	$25 Copayment per day
Organ Transplant Travel Services Maximum Maximum $10,000	
Short-term Rehabilitative Therapy 60 visit maximum per Member per Contract Year;	$10 Copayment per office visit
Self-Referred Chiropractic and Osteopathic Care Services 20 - visit maximum per Member per Contract Year	$10 Copayment per office visit

Total Copayment Maximum *		
Individual Member Total Copayment Maximum		$1,000 per Contract Year
Membership Unit Total Copayment Maximum		$2,000 per Contract Year

*Only Copayments identified in this Schedule of Copayments which have been paid by a Member for Inpatient Hospital, Outpatient Hospital Facility Services and Inpatient Services at Other Participating Health Care Facilities apply to these maximums

CIGNA HealthCare

Table of Contents

OUT-OF-NETWORK CERTIFICATE 132

SCHEDULE OF OUT-OF-NETWORK MEDICAL BENEFITS 134
MEDICAL CARE BENEFITS 135
HOW TO FILE YOUR CLAIM 136
WHO IS ELIGIBLE 136
ELIGIBILITY – EFFECTIVE DATE 136
REQUIREMENTS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA'93) 137
MAJOR MEDICAL BENEFITS 138
MEDICAL CONVERSION PRIVILEGE 143
GENERAL LIMITATIONS - MEDICAL BENEFITS 144
MEDICARE ELIGIBLES 146
COORDINATION OF BENEFITS 146
EXPENSES FOR WHICH A THIRD PARTY MAY BE LIABLE 148
PAYMENT OF BENEFITS 149
TERMINATION OF INSURANCE - EMPLOYEES 149
TERMINATION OF INSURANCE - DEPENDENTS 149
TERMINATION OF INSURANCE - CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS 150
TERMINATION OF INSURANCE - REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993 152
MEDICAL BENEFITS EXTENSION DURING HOSPITAL CONFINEMENT 153
ACCIDENT AND HEALTH PROVISIONS 153
DEFINITIONS 154
MISCELLANEOUS 159

CERTIFICATE RIDER 159

CIGNA HealthCare

Out-of-Network Medical Benefits

Out-of-Network Certificate

The benefits described in the pages to follow are underwritten by Connecticut General Life Insurance Company.

Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
a CIGNA company (called CG) certifies that it insures certain Employees for the benefits provided by the following policy:

POLICYHOLDER: FIRST SECURITY BANK OF UTAH
AS TRUSTEE OF THE HEALTH
ACCESS INSURANCE TRUST

GROUP POLICY(S) - COVERAGE
MEDICAL EXPENSE INSURANCE

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.

Susan L. Cooper

Corporate Secretary

CIGNA HealthCare

Out-of-Network Medical Benefits

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Notice of Federal Requirements

COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY
When a person insured for benefits under this certificate who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications in all stages of mastectomy, including lymphedema.

If you have any questions about your benefits under this Plan, please call the number on your ID card or contact your Employer.

GM6000 NOT 43

MATERNITY HOSPITAL STAY
Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable. Please review this Plan for further details on the specific coverage available to your and your Dependents.

GM6000 NOT 50

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section.

CIGNA HealthCare

Out-of-Network Medical Benefits

Schedule of Out-of-Network Medical Benefits

For You and Your Dependents

Lifetime Maximum	**5,000,000**
Major Medical Deductible After Major Medical Deductibles totaling **$600** have been applied in a Contract Year for either (a) you and your Dependents or (b) your Dependents, any Medical Deductible will be waived for your family for the rest of that Contract Year.	**$300**
Benefit Percentage for Covered Expenses incurred	**70%**
Individual Out-of-Pocket Control	**$3,000**
Family Out-of-Pocket Control (See section entitled "Full Payment Area")	**$6,000**
Outpatient Rehabilitative Therapy Maximum	**60 visits per Contract Year**
Home Health Care Maximum	**40 visits per Contract Year**
Skilled Nursing Facility Maximum	**90 days per Contract Year**
Durable Medical Equipment	**Not Covered**
External Prosthetic Appliances	**Not Covered**

The Inpatient, Outpatient, Home Health Care and Skilled Nursing Facility Maximums shown in this Schedule will be reduced by the number of days, visits or equivalent dollar amounts for which you receive Basic Benefits in the same Contract Year.

Out-of-Network Medical Benefits

Medical Care Benefits
For You and Your Dependents

Pre-Admission Certification/Continued Stay Review Requirements

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of any Hospital Confinement as a registered bed patient. PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted. PAC should be requested by you or your Dependent for each inpatient Hospital admission. CSR should be requested, prior to the end of the certified length of stay, for continued inpatient Hospital Confinement.

Expenses incurred for which benefits would otherwise be payable under this plan for the Hospital charges listed below will be reduced by $400 for:

- any Hospital charges made during any Hospital Confinement as a registered bed patient unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, by the end of the first scheduled work day after the date of admission.

Expenses incurred for which benefits would otherwise be payable under this plan will not include:

- Hospital charges for Bed and Board, during a Hospital Confinement for which PAC is performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges made during any Hospital Confinement as a registered bed patient: (a) for which PAC was performed; but (b) which was not certified as medically necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

You should start the PAC process by calling the Review Organization prior to an elective admission, or in the case of an emergency admission, by the end of the first scheduled work day after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. The Review Organization will continue to monitor the confinement until you are discharged from the Hospital. The results of the review will be communicated to you, the attending Physician, the Hospital, and CG.

The Review Organization is an organization with a staff of Registered Graduate Nurses and other trained staff members who perform the PAC and CSR process in conjunction with consultant Physicians.

Pre-authorization Requirement

Prior-authorization should be requested by you or your Dependent at least 14 days prior to the performance of diagnostic or surgical services performed at an Outpatient Surgical Facility and for magnetic resonance imaging.

Amounts for expenses incurred, which would otherwise be payable under this plan, will be reduced to $400 for services described above for which pre-authorization was not obtained.

Out-of-Network Medical Benefits

How to File Your Claim

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required CG claim forms from CIGNA HealthCare. All fully completed claim forms and bills should be filed through CIGNA HealthCare.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form from CIGNA HealthCare before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

Doctor's Bills and Other Medical Expenses

The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS

- BE SURE TO USE YOUR SOCIAL SECURITY NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

Who is Eligible

For Employee Insurance

You will become eligible for insurance on the later of:

- your Employer's Participation Date; or
- the date you become a member of a Class of Eligible Employees.

For Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

CLASSES OF ELIGIBLE EMPLOYEES

Each Employee who is enrolled for Basic Benefits

Eligibility – Effective Date

Employee Insurance

This plan is offered to you as an Employee. To be insured, you may have to pay part of the cost.

Out-of-Network Medical Benefits

Effective Date of Your Insurance

You will become insured on the date you become eligible; provided you have agreed to make the required contribution toward the cost of Employee Insurance if any, by signing an approved payroll deduction form.

Dependent Insurance

For your Dependents to be insured, you may have to pay part of the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you become eligible for Dependent Insurance for that Dependent; provided you have agreed to make the required contribution toward the cost of that insurance, if any, by signing an approved payroll deduction form. All of your Dependents, as defined, who are enrolled for Basic Benefits will be included.

Your Dependents will be insured only if you are insured.

Exception for Newborns

Any Dependent child born while you are insured for Dependent Insurance will be insured from his date of birth.

Any Dependent child born while you are insured for Medical Insurance for yourself, but not for your Dependents, will become insured for Medical Insurance on the date of his birth if you elect Dependent Medical Insurance no later than 31 days after his birth.

Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA'93)

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, where applicable.

A. Eligibility for Coverage under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child within 31 days of the court order being issued.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or state agency, and satisfies all of the following:

1. the order specifies your name and last known address, and the child's name and last known address;
2. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
3. the order states the period to which it applies; and
4. the order specifies each plan that it applies to.

Out-of-Network Medical Benefits

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit not otherwise provided under the policy.

B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exceptions for Newborns" section of this certificate that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Any "Pre-existing Condition Limitation" in this certificate will be waived for an adopted child or a child placed for adoption.

Major Medical Benefits
For You and Your Dependents

If you or any one of your Dependents, while insured for these benefits, incurs Covered Expenses, CG will pay an amount determined as follows:

The Benefit Percentage of Covered Expenses incurred as shown in The Schedule, if any, provided that: (1) the Hospital Deductible shown in The Schedule will first be deducted from the Covered Expenses incurred for charges made by a Hospital for each separate admission as a registered bed patient; (2) the Skilled Nursing Facility Deductible shown in The Schedule, if any, will first be deducted from the Covered Expenses incurred for charges made by a Skilled Nursing Facility for each separate confinement in a Skilled Nursing Facility; and (3) the Major Medical Deductible shown in The Schedule will first be deducted from all other Covered Expenses incurred for a person in each Contract Year.

Payment of any benefits will be subject to the Maximum Benefit Provision.

Full Payment Area

When the amount of Covered Expenses incurred by a person in a Contract Year for which no payment is provided because of Coinsurance, exclusive of any deductible, equals the Individual Out-of-Pocket Control shown in The Schedule, benefits for him for Covered Expenses incurred during the rest of that Contract Year will be payable at the rate of 100%.

When the combined amount of Covered Expenses incurred in a Contract Year by you and at least one of your Dependents or at least two of your Dependents for which no payment is provided because of Coinsurance, exclusive of any deductible, equals two times the Individual Out-of-Pocket Control shown in The Schedule, benefits for you and all of your Dependents for Covered Expenses incurred during the rest of that Contract Year will become payable at the rate of 100%, subject however to any applicable deductible amount not yet satisfied by you or any of your Dependents in that Contract Year.

Out-of-Network Medical Benefits

Any Hospital Deductible will continue to apply even though the rate at which benefits are payable changes. The Major Medical Deductible, if not yet satisfied, will continue to apply until it is satisfied.

Maximum Benefit Provision

The total amount of Major Medical Benefits payable for all expenses incurred for a person in his lifetime will not exceed the Maximum Benefit shown in The Schedule.

Covered Expenses

The term Covered Expenses means expenses incurred by or on behalf of a person for the charges listed below, after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are Medically Necessary, as determined by CG, for the care and treatment of an Injury or a Sickness:

- by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies and for medical care and treatment received as an outpatient; except that, for any day of Hospital Confinement in a private room, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Hospital's most common daily rate for a semi-private room.
- by a Physician for professional services.
- by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- by a Skilled Nursing Facility, on its own behalf, for medical care and treatment; except that for any day of Skilled Nursing Facility confinement, Covered Expenses will not include that portion which is more than the Skilled Nursing Facility's most common daily rate for a semiprivate room; nor will Covered Expenses include charges for any day of confinement in excess of the Skilled Nursing Facility Maximum shown in The Schedule.
- for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatments; chemotherapy; blood and blood products; and physical therapy provided by a licensed physical therapist; and drugs and medicines lawfully prescribed by a Physician, excluding vitamins.
- for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- for drugs and medicines lawfully dispensed only on the written prescription of a Physician, excluding vitamins; provided that benefits for Prescription Drugs are included in your Employer’s Plan as determined from The Schedule. In any event, drugs prescribed while a person is Confined in a Hospital will be covered.

Home Health Care Services

- charges made for Home Health Care 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 Health Care Facility.

Home Health Care Services are provided only if CG determines that the home is a medically appropriate and cost-effective setting.

Home Health Care Services are provided under the terms of a Home Health Care plan for the person named in that plan.

Out-of-Network Medical Benefits

If you are a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), Home Health Care Services will only be provided for you during times when there is a family member or care giver present in the home to meet your non-skilled care needs.

Home Health Care Services are those skilled health care services that can be provided during intermittent visits of 2 hours or less by Other Health Care Professionals. Necessary consumable medical supplies, home infusion therapy, and Durable Medical Equipment administered or used by Other Health Care Professionals in providing Home Health Care Services are covered. Home Health Care Services do not include 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. Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under "Short-term Rehabilitative Therapy".

Other Health Care Facilities are facilities other than a Hospital or a Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals and sub-acute facilities.

Other Health Care Professionals include an individual, other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services. Other Health Care Professionals include, but are not limited to physical therapists, home health aides and nurses.

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Expenses Not Covered

Covered Expenses will not include, and no payment will be made for, expenses incurred:

- for any services or supplies for which you or your Dependents receive Basic Benefits.
- for cosmetic surgery or therapy, unless performed for repair or correction of severe facial disfigurements or severe physical deformities that are congenital or result from developmental abnormalities (other than abnormalities of the jaw or TMJ disorder), tumors, trauma, disease or the complications of medically necessary, non-cosmetic surgery. Reconstructive surgery for correction of congenital birth defects or developmental abnormalities must be performed prior to your attainment of age 19. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by CG.
- for eyeglasses, hearing aids or examinations for prescription or fitting thereof.
- for or in connection with treatment of the teeth or periodontium.
- for or in connection with organ transplant services including immunosuppressive medication; organ procurement costs; or donor’s medical costs.
- for services provided for the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.
- for or in connection with any procedure or treatment related to infertility such as artificial insemination, in vivo or in vitro fertilization, gamete or zygote intrafallopian transfer procedures, or similar procedures; any cost associated with the collection, preparation or storage of sperm for artificial insemination; or oral or injectable drugs which promote fertility.
- for treatment of erectile dysfunction, except when an established medical condition is the cause of penile erectile dysfunction

Out-of-Network Medical Benefits

- for medical and surgical services intended primarily for the treatment or control of obesity which are not medically necessary as determined by the CG Provider Organization. Excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to assimilate food, gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejunal bypass.
- for dressings, ostomy supplies, and other consumable supplies, unless received while a person is Confined in a Hospital or when used by a skilled home care professional.
- for procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion.
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- for routine footcare, including paring and removing of corns and calluses or trimming of nails except when medically necessary.
- for membership costs or fees associated with health clubs or weight loss clinics.
- for non-medical ancillary services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation.
- for medical or surgical services for treatment for control of obesity, except when a person has complied with more conservative treatments for control of morbid obesity.
- for injectable drugs.
- for transsexual surgery (including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery) and penile implants.
- for reversal of voluntary sterilization procedures.
- for therapy to improve general physical condition, including, but not limited to, cardiac rehabilitation and pulmonary rehabilitation programs, and any rehabilitation therapy except as provided for short-term therapy as described in The Schedule.
- therapy to improve general physical condition including, but not limited to, routine, long term or non-medically necessary chiropractic care and rehabilitative services which are provided to reduce potential risk factors where significant therapeutic improvement is not expected.
- for fees associated with the collection of blood or blood products, except for autologous donation in anticipation of scheduled surgery where the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- for artificial aids including, but not limited to, crutches, splints, braces, corrective orthopedic shoes, arch supports, orthotics, elastic stockings, garter belts, corsets, hearing aids, eyeglass lenses and frames, contact lenses (except for the first pair of contact lenses for treatment of keratinous or post-cataract surgery), dentures and wigs.
- for treatment by acupuncture
- for amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder.

Out-of-Network Medical Benefits

- for the cost of biologicals that are immunizations or medicines for the purpose of travel, or to protect against occupational hazards and risks.
- for cosmetic, dietary supplements, nutritional formulae, and health and beauty aids.
- which satisfy the Hospital or Skilled Nursing Facility Deductible shown in The Schedule for Hospital Benefits.
- for Durable Medical Equipment or External Prosthetic Appliances.
- for or in connection with Mental Illness or Substance Abuse.
- for which benefits are not payable according to the "General Limitations" section.
- for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous, one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-Existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date that person: begins an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-existing Condition Limitation

Pregnancy and genetic information with no related treatment, will not be considered Pre-existing conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition Limitation. If such child was covered within 30 days of birth, adoption or placement for adoption. Such waiver will apply only if less than 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy, up to 12 months for a timely enrollee and 18 months for a Late Entrant.

Certification of Prior Creditable Coverage

You must provide proof of your prior Creditable Coverage in order to reduce a Pre-existing Condition limitation period. You should submit proof of prior coverage with your enrollment material. Certification, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent directly to: Eligibility Services, CIGNA HealthCare, P.O. Box 9077, Melville, NY 11747-9077. You should contact the plan administrator or CIGNA Customer Service Representative if assistance is needed to obtain proof of prior Creditable Coverage. Once your prior coverage records are reviewed and credit is calculated, you will receive a notice of any remaining Pre-existing condition limitation period.

Creditable Coverage

Creditable Coverage will include coverage under: a self-insured employer group health plan; individual or group health insurance indemnity or HMO plans; state or federal continuation coverage; individual or group health conversion plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; the Indian

Out-of-Network Medical Benefits

Health Service; the Peace Corps Act; a state health benefits risk pool; a public health plan; health coverage for current or former members of the armed forces and their Dependents; medical savings accounts; and health insurance for federal employees and their Dependents.

Medical Conversion Privilege For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by CG only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CG within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled To Convert

You are Entitled To Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- You have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- Your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance; or the policy cancelled.
- You are not eligible for Medicare.
- You would not be Overinsured.

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled To Convert

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents, if you are not Entitled to Convert solely because you are eligible for Medicare;

but only if that Dependent: (a) was insured when your insurance ceased; (b) is not eligible for Medicare; and (c) would not be Overinsured.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- His insurance under this plan is replaced by similar group coverage within 31 days.
- The benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on CG's underwriting standards for individual policies. Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; or (b) those

Out-of-Network Medical Benefits

for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of CG's current offerings at the time the first premium is received based on its rules for Converted Policies. It will comply with the laws of the jurisdiction where the group medical policy is issued. However, if the applicant for the Converted Policy resides elsewhere, the Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where he resides. The Converted Policy offering may include medical benefits on a group basis. The Converted Policy need not provide major medical coverage unless it is required by the laws of the jurisdiction in which the Converted Policy is issued.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: (a) class of risk and age; and (b) benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the period of the Medical Benefits Extension of this plan, the amount payable under the Converted Policy will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan.

CG or the Policyholder will give you, on request, further details of the Converted Policy.

General Limitations - Medical Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Sickness or Injury;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay or for which you are not billed or for which you would not have been billed except that they were covered under this policy;
- for charges which would not have been made if the person had no insurance;
- to the extent that they are more than Reasonable and Customary Charges;
- for charges for unnecessary care, treatment or surgery, except as specified in any certification requirement shown in the PAC/CSR Requirements and Pre-Authorization section, of the Medical Care Benefits section;
- for or in connection with Custodial Services, education or training;

Out-of-Network Medical Benefits

- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a co-surgeon in excess of the surgeon's allowable charge plus 20 percent; (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.);
- for charges made for or in connection with the purchase or replacement of contact lenses; except, the purchase of the first pair of contact lenses that follows cataract surgery will be covered;
- for charges for supplies, care, treatment or surgery which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by CG;
- for or in connection with speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
- for charges made by any covered provider who is a member of your family or your Dependent's family.
- for Experimental, Investigational or Unproven Services which are medical, surgical, psychiatric, substance abuse or other healthcare diagnoses, treatments, procedures, drug therapies, technologies, supplies or devices that are determined by CG, in its sole discretion, to be:

  (a) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information or in medical literature. Medical literature means scientific studies published in a peer reviewed national professional journal; or

  (b) the subject of review or approval by an Institutional Review Board for the proposed use; or

  (c) the subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or

  (d) not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

- for non-medical ancillary services, including but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation.
- to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

  a. "no-fault" insurance law; or

  b. an uninsured motorist insurance law.

  CG will take into account any adjustment option chosen under such part by you or any one of your Dependents.
- for or in connection with an elective abortion unless:

Out-of-Network Medical Benefits

a. the Physician certifies in writing that the pregnancy would endanger the life of the mother; or

b. the expenses are incurred to treat medical complications due to the abortion.

Medicare Eligibles

The Medical Expense Insurance for:

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

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

(c) an Employee of an Employer who participates in a group health plan in which all Participating Employers have fewer than 100 Employees, if that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee of an Employer who participates in a group health plan in which all Participating Employers have fewer than 100 Employees, if that Dependent is eligible for Medicare due to disability;

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

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

will be modified, where permitted by the rules established by the Social Security Act of 1965 as amended, as follows:

The amount payable under this plan will be reduced so that the total amount payable by Medicare and by CG will be no more than 100% of the expenses incurred.

CG will assume the amount payable under:

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

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

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

Coordination of Benefits

If you or any one of your Dependents is covered under more than on Plan (not including the Plan of Basic Benefits), benefits payable from all such Plans will be coordinated.

Out-of-Network Medical Benefits

Coordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses incurred in that Period, the sum of;

(a) the benefits that would be payable from this Plan in the absence of coordination; and

(b) the benefits that would be payable from all other Plans without Coordination of Benefits provisions in those Plans;

would exceed such Allowable Expenses.

The benefits that would be payable from this Plan for Allowable Expenses incurred in any Claim Determination Period in the absence of Coordination of Benefits will be reduced to the extent required so that the sum of:

(a) those reduced benefits; and

(b) all the benefits payable for those Allowable Expenses from all other Plans;

will not exceed the total of such Allowable Expenses. Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if: (a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and (b) the other Plan has a provision that coordinates its benefits with those of this Plan and would, based on its rules, determine its benefits after this Plan.

CG reserves the right to release to or obtain from any other Insurance Company or other organization of person any information which, in its opinion, it needs for the purpose of Coordination of Benefits.

When payments which should have been made under this Plan based on the terms of this section have been made under any other Plans, CG will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. CG will be released from all liability under this Plan to the extent of these payments. When an overpayment has been made by CG at any time, it will have the right to recover that payment, to the extent of the excess, form the person to whom it was made or any other Insurance Company or organization, as it may determine.

Plan

Plan means any of the following which provides medical or dental benefits or services: (a) individual, group, blanket or franchise insurance coverage other than blanket group or franchise school accident policies; (b) service plan contracts, group or individual practice or other prepayment plans; or (c) coverage under any: labor-management trustee plans; union welfare plans; employer organization plans; or employee benefit organization plans. Plan does not include coverage under hospital indemnity policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Allowable Expense

Allowable Expense means any necessary, reasonable and customary item of expense, at least a part of which is covered by any one of the plans that covers the person for whom claim is made. When the benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid. Allowable Expense will not include the difference between: (a) the cost of a private room; and (b) the cost of a semiprivate room; except while the person’s stay in a private room is medically necessary in terms of generally accepted medical practice.

Out-of-Network Medical Benefits

Claim Determination Period

Claim Determination Period means a contract year or that part of a contract year in which the person has been covered under this plan.

Benefit Determination Rules

The rules below establish the order in which benefits will be determined:

(1) The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a plan which covers that person as a dependent.

(2) The benefits of a Plan which covers the person for whom claim is made as a dependent of a person whose day of birth occurs first in a calendar year will be determined before a Plan which covers that person as a dependent of a person whose day of birth occurs later in that year; except that: (a) if the other Plan does not have this rule, its alternate rule will govern; and (b) in the case of a dependent child of divorced or separated parents, the rules in item (3) will apply.

(3) If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsibility will be determined before any other plan; otherwise:

(a) The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before a Plan which covers the child as a dependent of a stepparent or a parent without custody.

(b) The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.

(4) When the above rules do not establish the order, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time; except that:

(a) The benefits of a Plan which covers the person as a laid-off or retired employee, or his dependent will be determined after a Plan which covers the person as an employee, other than a laid-off or retired employee, or his dependent.

(b) If the other Plan does not have the rule in item (4)(a), which results in each Plan determining its benefits after the other, then item (4)(a) will not apply.

Expenses for Which a Third Party May Be Liable

This policy does not cover expenses for which another party may be responsible as a result of having caused or contributed to the Injury or Sickness. If you incur a Covered Expense for which, in the opinion of CG, another party may be liable:

1. CG shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Policy. You or your representative shall execute such documents as may be required to secure CG's subrogation rights.

2. Alternatively, CG may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to CG the lesser of:

a. the amount actually paid for such Covered Expenses by CG; or

Out-of-Network Medical Benefits

b. the amount you actually receive from the third party for such Covered Expenses;

at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or award or otherwise.

Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Termination of Insurance - Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.

Termination of Insurance - Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.

Out-of-Network Medical Benefits

- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

Termination of Insurance - Continuation Required by Federal Law for You and Your Dependents

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

A. Employees and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. To continue Medical Insurance, you must elect continuation coverage under Basic Benefits. You and your Dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; or (b) the date notice of the right to continue insurance is sent. You must pay the first premium within 45 days from the date you elect to continue coverage. Such insurance will not be continued by CG for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- after you elect to continue this insurance, the date you become entitled to Medicare, and for your Dependent, the date he first becomes entitled to Medicare;
- after you elect to continue this insurance, for you, the date you first become covered under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.
- the date your continuation coverage under Basic Benefits ends.

B. Dependent Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

(1) your death;

(2) divorce or legal separation; or

(3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the Employer. To continue Dependent Medical Insurance, you must elect continuation coverage under Basic Benefits for the Dependent. In the case of (2)

Out-of-Network Medical Benefits

or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of (1), (2) or (3) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare, following his/her enrollment in Medicare;
- the date the policy cancels; or
- after the Dependent elects to continue this insurance, the date the Dependent first becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above;
- the date continuation coverage under Basic Benefits for the Dependent ends.

C. Subsequent Events Affecting Dependent Coverage

If, within the initial 18 month continuation period, your Dependent would lose coverage because of an event described in (1), (2), or (3) of Section B, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your Dependent's coverage due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date your employment ends or your work hours are reduced.

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18-month period.

If you or your Dependents who are not disabled elect to continue coverage, such family members of the disabled person may extend coverage for up to an additional 11 months, if they otherwise remain eligible, and notice of disability is provided as described in (b), below.

To be eligible you or your Dependent must:

a) be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and

b) notify the plan administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the plan administrator with a copy of the determination.

Termination of coverage for all covered persons during the 29-month period 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 more than 30 days after the date of the final determination.

Out-of-Network Medical Benefits

All reasons for termination described in sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

D. Effect of Employer Chapter 11 proceedings on Retiree Coverage

If you are covered as a retiree, and a proceeding under USC Chapter 11, bankruptcy for the Employer results in a substantial loss of coverage for you or your Dependents within one year before or after such proceedings, 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.

Conversion Available Following Continuation

If you or your Dependent's Continuation ends due to the expiration of the maximum 18-, 29- or 36-month continuation period, whichever applies, you or your Dependent may be entitled to convert to the insurance in accordance with the Medical Conversion benefit then available to Employees and their Dependents.

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

- the required premium is paid; and
- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

If events (1) or (2) of Section B should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

Termination of Insurance - Requirements of Family and Medical Leave Act of 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

Out-of-Network Medical Benefits

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

Medical Benefits Extension During Hospital Confinement

If the medical benefits under this plan cease for you or your Dependent, and you or your Dependent are Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in The Schedule;
- The date you are covered for medical benefits under another group plan;
- The date you or your Dependent is no longer Hospital Confined;
- 3 months from the date your medical benefits cease.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when you or your Dependent's Medical Benefits cease.

Accident and Health Provisions

Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CG receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss requirements of the policy if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Out-of-Network Medical Benefits

Legal Actions

No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CG. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

Definitions

Basic Benefits

The term Basic Benefits means the group coverage provided by CIGNA HealthCare under its Group Service Agreement with the Employer.

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including mental illness, alcohol or drug abuse). Custodial Services include, but shall not be 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 usually be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

Contract Year

The term Contract Year is as defined for Basic Benefits under the Group Service Agreement.

Dependent

Dependents are any one of the following persons who are enrolled for Basic Benefits:

- your lawful spouse; and
- any unmarried child of yours who is
- less than 19 years old and primarily supported by you;
- 19 years but less than the limiting age for Basic Benefits, enrolled in school as a full-time student and primarily supported by you; and
- 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

Out-of-Network Medical Benefits

A child includes a legally adopted child, including that child from the first day of placement in your home. It also includes a stepchild who lives with you.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee

Durable Medical Equipment

The term Durable Medical Equipment means equipment which:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is generally not useful to a person in the absence of Sickness or Injury; and
- is appropriate for use in the home.

Employee

The term Employee means a full-time employee of the Employer.

Eligible Charges

Eligible Charges means charges made for treatment which is medically necessary.

Employer

The term Employer means an employer participating in the fund which is established under the agreement of Trust for the purpose of providing insurance.

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

External Prosthetic Appliance

The term External Prosthetic Appliance means a device which is used as a replacement or substitute for a missing body part and is necessary for the alleviation or correction of illness, injury or congenital defect.

Free-standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it has equipment for emergency care;
- it has a blood supply;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Home Health Aide

The term Home Health Aide means a person who: (a) provides care of a medical or therapeutic nature; and (b) reports to and is under the direct supervision of a Home Health Care Agency.

Out-of-Network Medical Benefits

Home Health Care Agency

The term Home Health Care Agency means a Hospital or a non-profit or public home health care agency which:

- therapeutic service under the supervision of a Physician or primarily provides skilled nursing service and other a Registered Graduate Nurse;
- is run according to rules established by a group of professional persons;
- maintains clinical records on all patients;
- does not primarily provide custodial care or care and treatment of the mentally ill;

but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

Home Health Care Plan

The term Home Health Care Plan means a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hospital or Skilled Nursing Facility if he did not have the care and treatment stated in the plan.

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals; or
- a Free-standing Surgical Facility.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- an outpatient in a Hospital because of: (a) chemotherapy treatment; (b) surgery; or (c) planned tests ordered by a Physician before inpatient admission to the same Hospital;
- receiving emergency care in a Hospital for an Injury, on his first visit as an outpatient within 48 hours after the Injury is received; or

The term Partially Confined means continually treated for at least 3 hours but not more than 12 hours in any 24-hour period.

Injury

The term Injury means an accidental bodily injury.

Out-of-Network Medical Benefits

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary/Medical Necessity

Health care services and supplies which are determined by CG to be: (a) medically required to meet the basic health needs of the insured; (b) consistent with the diagnosis of the condition; (c) consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; (d) required for purposes other than the comfort and convenience of the patient or their Physician; (e) rendered in the least intensive setting that is appropriate for the delivery of health care; and (f) of demonstrated medical value.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Mental Illness

The term "mental illness" means any disorder, other than a disorder induced by alcohol or drug abuse, which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological symptoms related to a mental illness will not be considered to be charges made for treatment of a mental illness.

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Outpatient Surgical Facility

The term Outpatient Surgical Facility means a licensed institution which: (a) has a staff that includes Registered Graduate Nurses; (b) has a permanent place equipped for performing Surgical Procedures; and (c) gives continuous Physician services on an outpatient basis.

Participation Date

The term Participation Date means the later of:

- The Effective Date of the policy; or
- The date on which your Employer becomes a participant in the plan of insurance authorized by the agreement of Trust.

Out-of-Network Medical Benefits

Pharmacy

The term Pharmacy means a licensed establishment where prescription drugs are dispensed by a pharmacist.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.

Reasonable and Customary Charge

A charge will be considered Reasonable and Customary if:

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CG.

To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

Sickness - For Medical Insurance

The term Sickness means a physical illness. It also includes pregnancy. Expenses incurred for routine care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DEF

Out-of-Network Medical Benefits

Miscellaneous

Additional Programs

CG may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Employees for the purpose of promoting their general health and well being. Contact CG for details of these programs.

Certificate Rider

EXHIBIT B 01178-RFP PPO

Application

Insured and/or Administered by
Connecticut General Life Insurance Company
CIGNA HealthCare

1. NAME OF APPLICANT	2. MAIN ADDRESS
Maricopa County	320 W. Lincoln Street, Phoenix, AZ 85003

3. NATURE OF BUSINESS
Municipality

4. CLASSES AND LOCATIONS OF INDIVIDUALS ELIGIBLE	5. SUBSIDIARY AND AFFILIATED COMPANIES INCLUDED

6. TOTAL NUMBER OF INDIVIDUALS ELIGIBLE	FOR INDIVIDUAL BENEFITS	FOR DEPENDENT BENEFITS
15,000	15,000	23,000

HAVE ANY OF THE CLASSES OF INDIVIDUALS ELIGIBLE BEEN COVERED UNDER A GROUP INSURANCE POLICY OR ANY OTHER FORM OF GROUP PLAN WITHIN THE PAST FIVE YEARS?

(X) **Yes** ( ) **No** IF SO, PLEASE SPECIFY THE BENEFITS, THE UNDERWRITING COMPANY OR ORGANIZATION, AND THE DATES THESE BENEFITS WERE TERMINATED

CIGNA

7. GROUP INSURANCE APPLIED FOR *(Please check all that apply)*

INDIVIDUAL	DEPENDENT	
( )	( )	Life Insurance
( )	( )	Accidental Death & Dismemberment Insurance
( )	--	Short Term Disability Insurance
( )	--	Long Term Disability Insurance
( )	( )	Hospital Benefits
( )	( )	Surgical Benefits
( )	( )	Doctors Attendance Benefits
( )	( )	Laboratory and X-ray Examination Benefits
( )	( )	Major Medical Benefits
(X)	(X)	Comprehensive Medical Benefits (PPO)
( )	( )	Dental Benefits
( )	( )	Vision Benefits
( )	( )	_____

8. Effective Date Requested: Januray 1, 2003

Group Insurance at the Insurance Company's rates and under the terms of the policy(s) applied for will take effect on the Effective Date Requested if the Application is accepted at the Home Office of the Insurance Company. If certain persons eligible are to contribute to the cost of the Group Insurance, such Group Insurance will take effect on the later of: the date the required number have enrolled, or on the Effective Date Requested. If this Application is not accepted, no insurance will become effective. Any premium advanced by the Applicant will be refunded upon surrender of this Conditional Receipt.

9. THE APPLICANT DECLARES: that he has read the above statement and the answers to the above questions are complete and true. The Applicant agrees: (1) that this Application is offered as an inducement for the Group Insurance applied for; (2) that this Application will form a part of any policy issued; (3) that only the information on this Application will bind the Insurance Company; and (4) that no waiver or change will bind the Insurance Company unless signed by an Executive Officer of the Insurance Company. Group Insurance will only be provided to persons eligible under the policy(s) issued.

Dated at _____ on _____

Name of Applicant Maricopa County

By _____ Title _____

Witness _____ Soliciting Agent if other than Witness _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TABLE OF CONTENTS

Page

Certification .....

The Schedule .....

Section 125 Plan .....

How to File Your Claim.....

Eligibility — Effective Date.....

Comprehensive Medical Benefits.....

Medical Conversion Privilege.....

General Limitations.....

Medicare Eligibles .....

Coordination of Benefits .....

Payment of Benefits.....

Termination of Insurance .....

Benefits Extension.....

Accident and Health Provisions .....

Summary Plan Description .....

Definitions.....

When you select a participating provider, this plan pays a greater share of the costs than if you were to select a non-participating provider. Participating providers include physicians, hospitals and other health care professionals and facilities. Consult your Physician Guide for a list of participating providers in your area. Participating providers are committed to providing you and your dependents appropriate care while lowering medical costs.

Services Available In Conjunction With Your Medical Plan

The following several pages describe helpful services available in conjunction with your medical plan. You can access these services simply by calling the toll-free number shown on the back of your ID card. These services are provided by Intracorp, a CIGNA Company and can help ensure that you and your covered Dependents benefit fully from your medical coverage.

CIGNA'S Toll-Free Care Line

CIGNA's toll-free care line is a service provided through Intracorp, a CIGNA company. You can talk to a health care professional during normal business hours, Monday through Friday, simply by calling the toll-free number shown on your ID card.

CIGNA's toll-free care line personnel can provide you with the names of participating providers. If you or your dependents need medical care, you may consult your Physician Guide which lists the participating providers in your area or call CIGNA's toll-free number for assistance. And, if you or your dependents need medical care while away from home, you may have access to a national network of participating providers through CIGNA's Away-From-Home Care feature. Call CIGNA's toll-free care line for the names of participating providers in other network areas. Whether you obtain the name of a participating provider from your Physician Guide or through the care line, it is recommended that you call the provider to confirm that he or she is a current participant in the CIGNA Preferred Provider Program prior to making an appointment.

Case Management

Case Management is a service provided through Intracorp, a CIGNA Company, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Intracorp Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

1. You, your dependent or an attending physician can request Case Management services by calling the **toll-free care line number** shown on the back of your ID card during normal business hours, Monday through

Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.

2. Intracorp assesses each case to determine whether Case Management is appropriate.
3. You or your dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
4. Following an initial assessment, the Case Manager works with you, your family and physician to determine the needs of the patient and to identify what alternate treatment programs are available. (For example, in-home medical care in lieu of an extended hospital convalescence.) You are not penalized if the alternate treatment program is not followed.
5. The Case Manager arranges for alternate treatment services and supplies, as needed. (For example, nursing services or a hospital bed and other durable medical equipment for the home.)
6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and physician as needed. (For example, by helping you to understand a complex medical diagnosis or treatment plan.)
7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

NOTICE of Federal Requirements

Coverage for Reconstructive Surgery Following Mastectomy

When a person insured for benefits under this certificate who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications in all stages of mastectomy, including lymphedema;

If you have any questions about your benefits under this plan, please call the number on your ID card or contact your employer.

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable. Please review this Plan for further details on the specific coverage available to you and your Dependents.

NOTICE OF FEDERAL REQUIREMENTS

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed Services Employment and Re-employment 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 and dental coverage for you and your Dependents. They do not apply to any Life, Short-term, or Long-term Disability or Accidental Death coverage.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependent as follows:

If your Employer is subject to federal continuation requirements called COBRA, you may continue benefits according to the federal continuation benefits shown in your certificate.

If your Employer is not subject to COBRA, you may continue benefits, by paying the required premium to your Employer, until the earliest of the following:

- 18 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 COBRA, or USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

NOTICE OF FEDERAL REQUIREMENTS

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Reinstatement of Benefits (applicable to all coverages)

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

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

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

NOTICE OF FEDERAL REQUIREMENTS

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Timeframes for Requesting Re-employment

When a leave ends, you must report your intent to return to work as follows:

- For leaves of less than 31 days or for a fitness exam, by reporting to your Employer by the next regularly scheduled work day following 8 hours of travel time.
- For leaves of 31 days or more but less than 181 days, by submitting an application to your Employer within 14 days; and
- For leaves of more than 181 days, by submitting an application to your Employer within 90 days.

Consult your Employer for more details regarding your rights and your Employer's obligations for re-employment.

This section will be superseded in whole or in part by any richer state-required provision shown in this certificate.

CIGNA HEALTHCARE'S CONFIDENTIALITY POLICIES*

To help you better understand how we protect your confidentiality, we are providing you with answers to some common questions about our confidentiality policies.

WHAT TYPES OF INFORMATION DO WE RECEIVE?

We receive information needed to administer your plan, including from plan participants who apply for coverage or who submit a claim, and information from medical providers and Employers.

HOW DO WE PROTECT CONFIDENTIAL INFORMATION?

CIGNA HealthCare Employees and organizations who act on behalf of CIGNA Healthcare are required to keep plan participants' personal information confidential. Here's what we are doing to help ensure this policy is followed:

- We have established a CIGNA HealthCare privacy program office, which is responsible for monitoring our compliance with confidentiality policies, and for educating the organization on the important topic;
- Whenever possible, we provide only aggregate information that does not identify any individual. If we need to share individually identifiable information, we have policies that protect confidentiality;
- Our employees may not disclose information to other employees except when it is needed to conduct CIGNA HealthCare business.
- We require a written agreement from companies and organizations, including plan sponsors, who receive confidential information from us. These companies and organizations agree that they will use any individually identifiable information only to administer the benefits plan in accordance with applicable laws;
- Sometimes we require a plan participant's written authorization before we disclose confidential information. For example, a request from a research organization or from a plan participant's attorney would require an authorization signed by the plan participant. If the request was for information about a minor or an adult who was unable to exercise rational judgment or to give informed consent, we would require an authorization from the plan participant's parent or legal guardian;
- We protect the confidentiality of information for former plan participants, just as we do for current plan participants.

CIGNA HEALTHCARE'S CONFIDENTIALITY POLICIES*

We have also taken the following steps to help make sure CIGNA HealthCare facilities have policies to protect confidential information:

- Access to our facilities is limited to authorized personnel.
- CIGNA HealthCare locations that maintain confidential information have procedures for accessing, labeling and storing confidential records.
- We have additional policies and procedures to protect confidential information when CIGNA HealthCare provides medical treatment in one of our affiliated medical facilities.

WHAT TYPES OF INFORMATION DO WE DISCLOSE, AND TO WHOM?

CIGNA HealthCare will not release confidential information unless it is necessary to administer the benefits plan or to support CIGNA HealthCare programs or services, such as our care management and wellness programs. We may disclose information relating to claims and the processing of claims to:

- Medical providers;
- Plan administrators;
- Insurers that provide reinsurance or excess (Stop Loss) insurance to an Employer;
- CIGNA HealthCare affiliated companies such as Intracorp, CIGNA Behavioral Health, Inc., CIGNA Dental companies and CIGNA Tel-Drug companies;
- Regulatory agencies (such as departments of insurance) and accreditation organizations (such as the National Committee for Quality Assurance.);
- Courts or attorneys who serve us with a subpoena;
- New insurers or claim administrators who assume responsibility for administering the benefit plan;
- Companies that assist CIGNA HealthCare in recovering overpayments;
- Companies that pay claims or perform utilization review services for CIGNA HealthCare;
- Companies that assist CIGNA HealthCare in recovering benefits that were paid for claims incurred as a result of third-party negligence; and
- Companies not affiliated with CIGNA HealthCare that perform other services for CIGNA HealthCare.

CIGNA HEALTHCARE'S CONFIDENTIALITY POLICIES*

HOW CAN PLAN PARTICIPANTS ACCESS THEIR CONFIDENTIAL INFORMATION?

Plan participants have a right to review their medical records and other personal information and can submit a written request for those records or information to the Physician or other health care provider who created the record or to CIGNA HealthCare. CIGNA HealthCare strives to make sure that information is accurate and complete. If a plan participant finds an error and wishes to correct it, he or she can contact the provider who created the record or CIGNA HealthCare.

HOW DO WE LET PLAN PARTICIPANTS KNOW ABOUT OUR CONFIDENTIALITY POLICY?

Often, plan participants are informed about our confidentiality policies and practices during enrollment. However, even if that is not practical (for example, when plan participants enroll by telephone), we strive to inform all prospective and current plan participants about our confidentiality policies and practices through plan and policy documents, newsletters and preenrollment materials.

*****CIGNA companies are providers of employee benefits, health care coverage, insurance products, investment management and financial services to businesses and individuals worldwide. "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Intracorp, CIGNA Behavioral Health, Inc., and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. "CIGNA Dental" refers to the following operation subsidiaries of CIGNA corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc. and its operating subsidiaries. "CIGNA Tel-Drug" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C., which are also operating subsidiaries of CIGNA Corporation.

NOTICE OF AN APPEAL OR A GRIEVANCE

The appeal or grievance provision in this certificate may be superceded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

ARIZONA
IMPORTANT NOTICE

This notice is to advise you that you can obtain a replacement Appeals Process Information Packet by calling the Customer Service Department at the telephone number listed on your identification card for "Claim Questions/Eligibility Verification" or for "Member Services".

The Information Packet includes a description and explanation of the appeal process at CG.

Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
a CIGNA company (called CG) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Maricopa County

GROUP POLICY(S) — COVERAGE:
Preferred Provider Plan

EFFECTIVE DATE: January 1, 2003

NOTICE

Any insurance benefits in this certificate will apply to an Employee only if: a) he has elected that benefit; and b) he has a "Final Confirmation Letter," with his name, which shows his election of that benefit.

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

Corporate Secretary

Susan L. Cooper

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

THE SCHEDULE

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS

For You and Your Dependents	This Plan Will Pay:
Maximum Benefits	
Lifetime Maximum Benefit	
In-Network	A. Unlimited
Out of Network	B. $5,000.00

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS

Skilled Nursing Facility Maximum	90 days per calendar year
Home Health Care Maximum	
In-Network	Unlimited
Out of Network	40 visits per calendar year

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS

For You and Your Dependents	This Plan Will Pay:
Outpatient Rehabilitative Therapy Maximum	60 days per calendar year
External Prosthesis Maximum	$1,000 per calendar year.
Durable Medical Equipment Maximum	$700 per calendar year
Preventive Care Maximums	
Well-Child Care including immunizations (through age 2)	Unlimited
Well-Woman Care	Unlimited

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS

For You and Your Dependents	This Plan Will Pay:
Hospice Care Maximum	Unlimited
Covered Expense Daily Limit	
Participating Provider Hospital	The Hospital's negotiated rate
Non-Participating Provider Hospital	The Hospital's most common daily rate for a semiprivate room
Participating Provider Skilled Nursing Facility	The Skilled Nursing Facility's negotiated rate

Non-Participating Provider Skilled Nursing Facility	The Skilled Nursing Facility's most common daily rate for a semiprivate room
Participating Provider Hospice Facility	The Hospice Facility's negotiated rate
Non-Participating Provider Hospice Facility	The Hospice Facility's most common daily rate for a semiprivate room

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS (Cont.)

For You and Your Dependents

Deductibles

The Deductibles listed below are expenses to be paid by an Employee or a Dependent for the services rendered. These Deductibles are in addition to any other expenses incurred for which no benefits are payable because of any coinsurance factor:

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for the services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from, and are not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance.

Participating Provider Office Visit Copayment	
Specialty Provider	$ 30 Per Visit
Maternity	$ 20 for first visit to confirm pregnancy, then the Plan pays 100%, of charges for remaining visits and delivery
Urgent Care Center	$50 per visit
All other Office Visits	$ 20 then the Plan pays 100%

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS (Cont.)

For You and Your Dependents

Participating and Non-Participating Provider	
Emergency Room Deductible	$ 100 per visit
External Prosthetic Appliances	$ 200 Per visit
Participating Provider Deductible	$ 250
Non-Participating Provider Deductible	$ 750

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS (Cont.)

For You and Your Dependents

Family Deductibles

Participating Provider
Family Deductible $ 500

After Participating Provider Comprehensive Medical Deductibles totaling $ 500 have been applied in a calendar year for either: (a) you and your Dependents; or (b) your Dependents, your family need not satisfy any further Participating Provider Comprehensive Medical Deductibles for the rest of that year.

Non-Participating Provider
Family Deductible $ 1,500

After Non-Participating Provider Comprehensive Medical Deductibles totaling $ 1,500 have been applied in a calendar year for either: (a) you and your Dependents; or (b) your Dependents, your family need not satisfy any further Non-Participating Provider Comprehensive Medical Deductibles for the rest of that year.

Simultaneous Accumulation of Deductibles

Expenses incurred for either Participating or Non-Participating Provider charges will be used to satisfy both the Participating Provider Deductible and the Non-Participating Provider Deductible simultaneously, until the Participating Provider Deductible has been satisfied. However, only charges made by Non-Participating Providers will be used to satisfy the remainder of the Non-Participating Provider Deductible.

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS (Cont.)

For You and Your Dependents

Benefit Percentage

The Benefit Percentage for Covered Expenses incurred for charges made by a Participating or a Non-Participating Provider is as follows:

	Participating Provider	Non-Participating Provider
Emergency Services	100%	100%
Preventive Care		
Well-Child Care including immunizations (Birth through age 2)	100%	Not covered
Annual Routine Physicals	80%	Not Covered
Well-Woman Coverage	100%	Not Covered
All Other Covered Expenses	80%	60%

The Benefit Percentages above for Physician and professional services will be based on allowed charge.

THE SCHEDULE

MEDICAL CARE BENEFITS

For You and Your Dependents

PAC/CSR REQUIREMENTS. Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of any Hospital Confinement as a registered bed patient. PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted. PAC should be requested by you or your Dependent for each inpatient Hospital admission. CSR should be requested, prior to the end of the certified length of stay, for continued inpatient Hospital Confinement.

Expenses incurred for which benefits would otherwise be paid under this plan will not include the first $400 of Hospital charges made for each separate admission to the Hospital as a registered bed patient unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, by the end of the first scheduled work day after the date of admission.

The amount otherwise payable under this plan for the Hospital charges listed below will be reduced by $400 for:

- Hospital charges for Bed and Board, during a Hospital Confinement for which PAC is performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges made during any Hospital Confinement as a registered bed patient: (a) for which PAC was performed; but (b) which was not certified as medically necessary.

THE SCHEDULE

MEDICAL CARE BENEFITS

For You and Your Dependents (Continued)

PAC/CSR REQUIREMENTS (Continued)

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

You should start the PAC process by calling the Review Organization prior to an elective admission, or in the case of an emergency admission, by the end of the first scheduled work day after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. The Review Organization will continue to monitor the confinement until you are discharged from the Hospital. The results of the review will be communicated to you, the attending Physician, and CG.

The Review Organization is an organization with a staff of Registered Graduate Nurses and other trained staff members who perform the PAC and CSR process in conjunction with consultant Physicians.

EFFECT OF SECTION 125 REGULATIONS ON THIS PLAN

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 pre-tax salary reduction put toward the cost of your benefits. Otherwise you will receive your taxable earnings as cash (salary).

Provisions in this certificate which allow for enrollment or coverage changes not consistent with Section 125 Regulations are superseded by this section.

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 you enroll for or change coverage within 30 days of the following:

Special Enrollment

Special Enrollment per federal requirements as described in the Section entitled “ELIGIBILITY – EFFECTIVE DATE/Exception to Late Entrant Definition” **if** included in this document.

EFFECT OF SECTION 125 REGULATIONS ON THIS PLAN

Change in Status

A change in coverage due to the following changes in status: a) change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation; b) change in number of dependents due to birth, adoption, placement for adoption or death of a dependent; c) 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 Family and Medical Leave Act (FMLA) or change in worksite; d) changes in employment status of Employee, spouse or dependent resulting in eligibility or ineligibility for coverage; e) change in residence of Employee, spouse or dependent; and f) changes which cause a dependent to become eligible or ineligible for coverage.

Any changes in coverage must pertain directly to the change in status.

Court Order

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

Medicare Eligibility/Entitlement

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

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.

CHANGE 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 Eligibility/Entitlement; or c) this Plan and the other plan have different periods of coverage.

HOW TO FILE YOUR CLAIM

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card certifies that you are insured and tells the Hospital to send its bills directly to CG.

Doctor's Bills and Other Medical Expenses

The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS

- BE SURE TO USE YOUR SOCIAL SECURITY AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

  YOUR ACCOUNT NUMBER IS THE NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

ELIGIBILITY — EFFECTIVE DATE

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 30 hours a week.

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

Initial Employee Group: !

New Employee Group: !

Classes of Eligible Employees

!

ELIGIBILITY — EFFECTIVE DATE

Employee Insurance

This Plan is offered to you as an Employee. To be insured, you will have to pay part of the cost.

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction form, but no earlier than the date you become eligible. If you are a Late Entrant, your insurance will not become effective until CG agrees to insure you. You will not be denied enrollment for Medical Insurance due to your health status.

You will become insured on the first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction.

ELIGIBILITY - EFFECTIVE DATE

Exception to Late Entrant Definition

A person will not be considered a Late Entrant when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to such coverage; he lost prior coverage due to the employer's failure to pay premium; he is no longer eligible for prior coverage; or if such prior coverage was continuation coverage and the continuation period has been exhausted; and he enrolls for this coverage within 30 days after losing or exhausting prior coverage; or if he is a Dependent spouse or minor child enrolled due to a court order within 30 days after the court order is issued.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective, on the date of marriage, birth, adoption, or placement for adoption.

Pre-Existing Condition Limitation for Late Entrant

For plans which include a Pre-existing Condition limitation, the one-year waiting period before coverage begins for such conditions, will be increased to 18 months for a Late Entrant.

For plans which do not include a Pre-existing Condition limitation, you may be required to wait until the next plan enrollment period to enroll for coverage under the plan, if you are a Late Entrant.

For plans which do not standardly include a Pre-existing Condition limitation and which do not include an annual open enrollment period, a Pre-existing condition limitation of 18 months will apply for a Late Entrant only.

ELIGIBILITY - EFFECTIVE DATE

Dependent Insurance

For your Dependents to be insured, you will have to pay part of the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until CG agrees to insure that Dependent.

Your Dependents will be insured only if you are insured.

Late Entrant - Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction.

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance will become insured for Medical Insurance on the date of his birth if you elect Dependent Medical Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

REQUIREMENTS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA'93)

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, as amended, where applicable.

A. Eligibility for Coverage under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the Qualified Medical Child Support Order being issued.

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 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:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. 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;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. 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 requirements above.

REQUIREMENTS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA'93) (Continued)

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with State laws regarding child health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, the child's custodial parent or legal guardian, or a State official whose name and address have been substituted for the name and address of the child.

B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exceptions for Newborns" section of this certificate that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Any "Pre-existing Condition Limitation" in this certificate will be waived for an adopted child or a child placed for adoption.

COMPREHENSIVE MEDICAL BENEFITS

For You and Your Dependents

If you or any one of your Dependents, while insured for these benefits, incurs Covered Expenses, CG will pay an amount determined as follows:

> The Benefit Percentage of Covered Expenses incurred as shown in The Schedule, after deducting any Comprehensive Medical Deductible shown in The Schedule from the Covered Expenses first incurred for a person in each calendar year.

Payment of any benefits will be subject to: (a) any applicable deductibles and maximum benefits shown in The Schedule; and (b) the Maximum Benefit Provision.

COMPREHENSIVE MEDICAL BENEFITS

Full Payment Area - For Participating Provider Expenses

When a person has incurred Out-of-Pocket Expenses of $2,000 in a calendar year, benefits for him for Covered Expenses incurred for charges made by a Participating Provider during the rest of that calendar year will be payable at the rate of 100%.

When you and at least one of your Dependents or at least two of your Dependents have incurred a combined amount of Out-of-Pocket Expenses of $6,000 in a calendar year, benefits for you and all of your Dependents for Covered Expenses incurred for charges made by a Participating Provider during the rest of that calendar year will become payable at the rate of 100%.

All benefit deductibles will continue to apply. Any Comprehensive Medical Deductible, if not yet satisfied, will continue to apply until it is satisfied.

Full Payment Area - For Non-Participating Provider Expenses

When a person has incurred Out-of-Pocket Expenses of $4,000 in a calendar year, benefits for him for Covered Expenses incurred for charges made by a non-Participating Provider during the rest of that calendar year will be payable at the rate of 100%.

When you and at least one of your Dependents or at least two of your Dependents have incurred a combined amount of Out-of-Pocket Expenses of $12,000 in a calendar year, benefits for you and all of your Dependents for Covered Expenses incurred for charges made by a non-Participating Provider during the rest of that calendar year will become payable at the rate of 100%.

All benefit deductibles will continue to apply. Any Comprehensive Medical Deductible, if not yet satisfied, will continue to apply until it is satisfied.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges made by both Participating and non-Participating Providers for which no payment is provided because of any Copayments, any Comprehensive Medical Deductible (including any benefit deductibles) and the coinsurance factor.

COMPREHENSIVE MEDICAL BENEFITS

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below, if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are essential for the necessary care and treatment of an Injury or a Sickness.

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limits shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf, for medical care and treatment.
- charges made by a Skilled Nursing Facility, on its own behalf, for medical care and treatment; except that Covered Expenses will not include that portion which is more than the Skilled Nursing Facility Limit shown in The Schedule.
- Charges incurred at birth for the delivery of a child only to the extent that they exceed the birth mother's coverage, if any, provided: a) that child is legally adopted by you within one year from the date of birth; b) you are legally obligated to pay the cost of the birth; c) you notify CG of the adoption within 60 days after approval of the adoption or a change in the insurance policies, plans or company; and d) you choose to file a claim for such expenses subject to all other terms of these medical benefits.

Covered Expenses

- charges made by a facility licensed to furnish treatment of alcohol and drug abuse, on its own behalf, for care and treatment provided on an outpatient basis.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse for professional nursing service.
- charges made for anesthetics and their administration; diagnostic X-ray and laboratory examinations; X-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen

and other gases and their administration; rental or, at CG's option, purchase of Durable Medical Equipment; therapy provided by a licensed physical, occupational or speech therapist; prosthetic appliances; prostheses following a mastectomy; dressings; and drugs and medicines lawfully dispensed only upon the written prescription of a Physician while confined in a Hospital.

- Charges made by a Home Health Care Agency for any home health service which a Physician has prescribed in place of Hospital service, provided the service would qualify as a Covered Expense if performed in a Hospital.
- In connection with mammograms for breast cancer screening performed on dedicated equipment for diagnostic purposes on referral by a patient's Physician, not fewer than: (a) a baseline mammogram for women age 35 to 39, inclusive; (b) a mammogram for women age 40 to 49, inclusive, every two or more frequently based on the attending Physician's recommendation; or (c) a mammogram every year for women age 50 and over.
- charges made for or in connection with approved organ transplant services, including immunosuppressive medication; organ procurement costs; and donor's medical costs. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other Plan. Certain transplants will not be covered based on General Limitations. Contact CG before you incur any such costs.
- charges made by a Participating Provider for visits for routine preventive care of a Dependent child during the first two years of that Dependent child's life, including immunizations.
- charges made by a Participating Provider for: (a) an annual routine physical examination; (b) immunizations; (c) an annual mammogram; and (d) Papanicolaou laboratory screening tests.
- coverage for reconstructive breast surgery following a mastectomy. The breast that had the mastectomy as well as the unaffected breast will be covered in order to provide a symmetrical appearance. It will also include prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy. Coverage will be provided in a manner determined to be appropriate by the Physician in consultation with the insured.
- Ostomy supplies and urinary catheters

The following benefits will apply to insulin and noninsulin dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- charges for Durable Medical Equipment, including glucagon emergency kits and podiatric appliances, related to diabetes. A special maximum will not apply.
- charges for insulin, syringes; prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips; urine test strips, lancets; and alcohol swabs.
- charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
  - (a) Medically Necessary visits when diabetes is diagnosed;
  - (b) visits following a diagnosis of a significant change in the symptoms or conditions that warrant changes in self-management;
  - (c) visits when reeducation or refresher training is prescribed by the Physician; and
  - (d) medical nutrition therapy related to diabetes management.

- charges made due to Terminal Illness for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Limit shown in The Schedule;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within one year after the person's death;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by a Home Health Care Agency for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of a Home Health Aide;
    - physical, occupational and speech therapy;
    - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the 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;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;

- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;
- for more than three bereavement counseling sessions.

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for, expenses incurred:

- for or in connection with cosmetic surgery unless: (a) a person receives an Injury which results in bodily damage requiring the surgery; (b) it qualifies as reconstructive surgery performed on a person following surgery, and both the surgery and the reconstructive surgery are essential and medically necessary; (c) it qualifies as reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to achieve symmetry; or (d) it is performed to correct a congenital abnormality on one of your Dependents who has not reached skeletal maturity.
- for eyeglasses, or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses or contact lenses that follows cataract surgery.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by the outpatient department of a Hospital in connection with surgery.
- for prescription drug charges made for a person who is not Confined in a Hospital.
- for which benefits are not payable according to the "General Limitations" section; except that the limitations with respect to a maximum for multiple surgical procedures and an allowable charge for an assistant surgeon or cosurgeon will not apply to charges made by a Participating Provider.
- or or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person; begins an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-existing Condition Limitation

Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered within 31 days of birth, adoption or placement for adoption. Such waiver will not apply if 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage Under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy.

Certification of Prior Creditable Coverage

You must provide proof of your prior Creditable Coverage in order to reduce a Pre-existing Condition limitation period. You should submit proof of prior coverage with your enrollment material. Certification, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent directly to: Eligibility Services, CIGNA HealthCare, P.O. Box 9077, Melville, NY 11747-9077. You should contact the plan administrator or CIGNA Customer Service Representative if assistance is needed to obtain proof of prior Creditable Coverage. Once your prior coverage records are reviewed and credit is calculated, you will receive a notice of any remaining Pre-existing Condition limitation period.

Creditable Coverage

Creditable Coverage will include coverage under: a self-insured employer group health plan; individual or group health insurance indemnity or HMO plans; state or federal continuation coverage; individual or group health conversion plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; the Indian Health Service; the Peace Corps Act; a state health benefits risk pool; a public health plan; health coverage for current and former members of the armed forces and their Dependents; medical savings accounts; and health insurance for federal employees and their Dependents.

MEDICAL CONVERSION PRIVILEGE

For You And Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by CG only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CG within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled To Convert

You are Entitled To Convert Medical Expense Insurance for yourself and all of your Dependents who are insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- Your insurance ceased because:
  - you were no longer in Active Service; or
  - you were no longer eligible for Medical Expense Insurance.
- You are not eligible for Medicare.
- You would not be Overinsured.

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled To Convert

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents, if you are not Entitled to Convert solely because you are eligible for Medicare;

but only if that Dependent: (a) was insured when your insurance ceased; (b) is not eligible for Medicare; and (c) would not be Overinsured.

MEDICAL CONVERSION PRIVILEGE

Overinsured

A person will be considered Overinsured if either of the following occurs:

- His insurance under this plan is replaced by similar group coverage within 31 days.
- The benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on CG's underwriting standards for individual policies. Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; or (b) those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of CG's current offerings at the time the first premium is received based on its rules for Converted Policies. It will comply with the laws of the jurisdiction where the group medical policy is issued. However, if the applicant for the Converted Policy resides elsewhere, the Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where he resides. The Converted Policy offering may include medical benefits on a group basis. The Converted Policy need not provide major medical coverage unless it is required by the laws of the jurisdiction in which the Converted Policy is issued.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: (a) class of risk and age; and (b) benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan.

CG or the Policyholder will give you, on request, further details of the Converted Policy.

GENERAL LIMITATIONS
MEDICAL BENEFITS

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Sickness or Injury;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that they are more than Reasonable and Customary Charges;
- for charges for unnecessary care, treatment or surgery, except as specified in any certification requirement shown in The Schedule;
- for or in connection with Custodial Services, education or training;
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled: "Caution - limited by federal law to investigational use";
- for or in connection with experimental procedures or treatment methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society;
- to the extent of the exclusions imposed by any certification requirement shown in The Schedule;
- for charges made by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and $^{1}/_{2}$ of the amount otherwise payable for all other surgical procedures;
- for or in connection with in vitro fertilization, artificial insemination or similar procedures.
- for charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a cosurgeon in excess of the surgeon's allowable charge plus 20 percent (for purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts);
- for charges made for or in connection with the purchase or replacement of contact lenses; except, the purchase of the first pair of contact lenses that follows cataract surgery will be covered;
- for charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn;
- for charges for supplies, care, treatment or surgery which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by CG;
- for charges made for or in connection with tired, weak or strained feet for which treatment consists of routine footcare, including but not limited to, the removal of calluses and corns or the trimming of nails unless medically necessary;
- for or in connection with speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
- for charges made by any covered provider who is a member of your family or your Dependent's family.

No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

- a "no-fault" insurance law; or
- an uninsured motorist insurance law.

CG will take into account any adjustment option chosen under such part by you or any one of your Dependents.

MEDICARE ELIGIBLES

The Medical Expense Insurance for:

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

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

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

disability;

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

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

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

will be modified, where permitted by the rules established by the Social Security Act of 1965 as amended, as follows:

The amount payable under this plan will be reduced so that the total amount payable by Medicare and by CG will be no more than 100% of the expenses incurred.

CG will assume the amount payable under:

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

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

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

COORDINATION OF BENEFITS

If you or any one of your Dependents is covered under more than one Plan, benefits payable from all such Plans will be coordinated.

Coordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses incurred in that Period, the sum of:

(a) the benefits that would be payable from this Plan in the absence of coordination; and

(b) the benefits that would be payable from all other Plans without Coordination of Benefits provisions in those Plans;

would exceed such Allowable Expenses.

The benefits that would be payable from this Plan for Allowable Expenses incurred in any Claim Determination Period in the absence of Coordination of Benefits will be reduced to the extent required so that the sum of:

(a) those reduced benefits; and

(b) all the benefits payable for those Allowable Expenses from all other Plans;

will not exceed the total of such Allowable Expenses. Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if: (a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and (b) the other Plan has a provision that coordinates its benefits with those of this Plan and would, based on its rules, determine its benefits after this Plan.

If however, the insured is a member of a prepaid dental plan and is also an insured under an indemnity dental plan, the indemnity plan will be primary. The indemnity dental plan's payment will never exceed the member's obligation under the prepaid dental plan.

COORDINATION OF BENEFITS

CG reserves the right to release to or obtain from any other Insurance Company or other organization or person any information which, in its opinion, it needs for the purpose of Coordination of Benefits.

When payments which should have been made under this Plan based on the terms of this section have been made under any other Plans, CG will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. CG will be released from all liability under this Plan to the extent of these payments. When an overpayment has been made by CG at any time, it will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other Insurance Company or organization, as it may determine.

Plan

Plan means any of the following which provides medical or dental benefits or services: (a) group, blanket or franchise insurance coverage; (b) service plan contracts, group or individual practice or other prepayment plans; or (c) coverage under any: labor-management trusteed plans; union welfare plans; employer organization plans; or employee benefit organization plans. Plan does not include coverage under individual policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Allowable Expense

Allowable Expense means any necessary, reasonable and customary item of expense, at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When the benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid. Allowable Expense will not include the difference between: (a) the cost of a private room; and (b) the cost of a semiprivate room; except while the person's stay in a private room is medically necessary in terms of generally accepted medical practice.

Claim Determination Period

Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under this Plan.

COORDINATION OF BENEFITS

Benefit Determination Rules

The rules below establish the order in which benefits will be determined:

(1) The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a Plan which covers that person as a dependent.

(2) The benefits of a Plan which covers the person for whom claim is made as a dependent of a person whose day of birth occurs first in a calendar year will be determined before a Plan which covers that person as a dependent of a person whose day of birth occurs later in that year; except that: (a) if the other Plan does not have this rule, its alternate rule will govern; and (b) in the case of a dependent child of divorced or separated parents, the rules in item (3) will apply.

(3) If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:

(a) The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before a Plan which covers the child as a dependent of a stepparent or a parent without custody.

(b) The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.

(4) When the above rules do not establish the order, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time; except that:

(a) The benefits of a Plan which covers the person as a laid-off or retired employee, or his dependent will be determined after a Plan which covers the person as an employee, other than a laid-off or retired employee, or his dependent.

(b) If the other Plan does not have the rule in item (4)(a), which results in each Plan determining its benefits after the other, then item (4)(a) will not apply.

PAYMENT OF BENEFITS

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

TERMINATION OF INSURANCE - EMPLOYEES

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

Retirement (for Medical Insurance)

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels the insurance.

TERMINATION OF INSURANCE - DEPENDENTS

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

TERMINATION OF INSURANCE

Reinstatement of Insurance

If your Insurance ceases because you are called to active duty from status as a reservist on or after August 22, 1990, the insurance for you and your Dependents, including those born during your time of active duty, will be reinstated after your deactivation, provided you apply for reinstatement within 90 days of discharge or within one year of continuous hospitalization from the date of discharge.

Such reinstatement will be without the application of: a) a new waiting period, or b) a new Pre-existing Condition Limitation. A new Pre-existing Condition Limitation will not be applied to a condition that you or your Dependent may have developed while coverage was interrupted. However, no payment will be made for a condition that was the direct result of active military duty.

Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of

your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

A. Employees and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. You and your Dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; (b) the date notice of the right to continue insurance is sent; (c) the date the insurance would otherwise cease. You must pay the first premium within 45 days from the date you elect to continue coverage. Such insurance will not be continued by CG for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- after you elect to continue this insurance, the date you first become entitled to Medicare, and for your Dependent, the date he first becomes entitled to Medicare;
- after you elect to continue this insurance, for you, the date you first become covered under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

B. Dependent Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

(1) your death;

(2) divorce or legal separation; or

(3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the Employer. In the case of (2) or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of (1), (2) or (3) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare;
- the date the policy cancels; or
- after the Dependent elects to continue this insurance, the date the Dependent first becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

C. Subsequent Events Affecting Dependent Coverage

If, within the initial 18 month continuation period, your Dependent would lose coverage because of an event described in (1), (2), or (3) of Section B, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your Dependent's coverage due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours

If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date your employment ends or your work hours are reduced.

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18-month period.

If you or your Dependents who are not disabled elect to continue coverage, such family members of the disabled person may extend coverage for up to an additional 11 months, if they otherwise remain eligible, and notice of disability is provided as described in (b), below.

To be eligible you or your Dependent must:

a) be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the

Social Security Administration; and

b) notify the plan administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the plan administrator with a copy of the 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 more than 30 days after the date of the final determination.

All reasons for termination described in sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

D. Effect of Employer Chapter 11 Proceedings on Retiree Coverage

If you are covered as a retiree, and a proceeding under USC Chapter 11, bankruptcy for the Employer results in a substantial loss of coverage for you or your Dependents within one year before or after such proceeding, coverage will continue until: (a) for you, your death; and (b) for you Dependent surviving spouse or Dependent child, up to 36 months from your death.

E. Payment of Premium

This Plan may require the payment of an amount that does not exceed 102% of the applicable premium, except this Plan may require payment of up to 150% of the Applicable Premium for any extended period of continuation of coverage for a covered person who is disabled. The additional 48% may only be applied to the premium for the rating category that includes the disabled individual, and only for the additional 11 months.

Applicable Premium is determined as follows:

1. if the Employee alone elects to continue coverage, the Employee will be charged the active Employee rate;
2. if a Dependent spouse alone elects to continue coverage, the spouse will be charged the active Employee rate;
3. if a Dependent child or children elect to continue coverage without a parent also electing the continuation, each child will be charged the active Employee rate;
4. if the entire family elects to continue coverage, they will be charged the family rate;
5. if the Schedule of Premium Rates is set up on a step-rate basis, the active rate basis that fits the individuals who elect to continue their coverage is the rate that will be charged. If only children elect to continue coverage, each child will be charged the Employee Only rate.

Timely Payment

If payment is made within the grace period in an amount not significantly less than the amount the Plan requires to be paid, the amount must be deemed to satisfy the Plan’s requirement. However, you must be notified and allowed at least 30 days after notice is provided for payment to be made.

F. Providing Notification of Your Status to Health Care Providers During the Grace Period

If, after you elect to continue coverage, a health care provider contacts this Plan to confirm coverage for a period for which premium has not yet been received, the Plan must give a complete and accurate response.

G. Notification Requirements

Your Employer should send you initial notification of coverage continuation rights as required by federal law; (a) when the Plan first becomes subject to federal continuation requirements; (b) when you are hired; and (c) when you add a spouse as a Dependent for benefits under the Plan. Receipt of this certificate may serve as such notice.

If you become eligible to continue coverage per federal law, your Employer must send you notification within 14 days. If the Plan has a Plan Administrator, the Employer must notify the Plan Administrator within 30 days. The Plan Administrator must notify you within 14 days thereafter.

If eligibility to continue coverage is due to divorce, legal separation or a Dependent child losing eligibility for coverage under the Plan, you or your Dependent spouse must notify your Employer within 60 days of such event. Your Employer must notify you of the right to continue coverage within 14 days after receipt of notification of such event.

Conversion Available Following Continuation

If you or your Dependent's Continuation ends due to the expiration of the maximum 18-, 29- or 36-month continuation period, whichever applies, you or your Dependent may be entitled to convert to the insurance in accordance with the Medical Conversion benefit then available to Employees and their Dependents.

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

- the required premium is paid; and
- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

If events (1) or (2) of Section B should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

TERMINATION OF INSURANCE

REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

MEDICAL BENEFITS EXTENSION

Any expense incurred within one year after a person's Comprehensive Medical Benefits cease will be deemed to be incurred while he is insured if such expense is for an Injury or Sickness which causes him to be Totally Disabled from the day his insurance ceases until that expense is incurred.

The terms of this Medical Benefits Extension will not apply to: (a) a child born as a result of a pregnancy which exists when a person's benefits cease; or (b) any person when he becomes insured under another group policy for medical benefits.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

ACCIDENT AND HEALTH PROVISIONS

Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CG receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss requirements of the policy if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Legal Actions

No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CG. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

The following complies with federal law and is effective July 1, 2002. Provisions of the laws of your state may supersede.

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

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the toll-free number on your Benefit Identification card, explanation of benefits or claim form and explain your concern to one of our Member Services representatives. You can also express that concern in writing.

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

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

Appeals Procedure

CG has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CG within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CG to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits, or claim form.

Level One Appeal

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

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required pre-service or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness the Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

Independent Review Procedure

If you are not fully satisfied with the decision of CG's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CG's level two appeal review denial. CG will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your medical condition, as determined by CG's Physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by CG.

Appeal to the State

You have the right to contact the Department of Insurance/Health for assistance at any time.

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provision on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

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

Relevant Information

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

Legal Action

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

ARBITRATION

This provision does not apply to dental plans.

To the extent permitted by law, any controversy between CG and the Group, or an insured (including any legal representative acting on behalf of a Member), arising out of or in connection with this Certificate may be submitted to arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the

Commercial Arbitration Rules of the American Arbitration Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of the written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15 working day period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

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

SUMMARY PLAN DESCRIPTION

The name of the Plan is:

!

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

!

Employer Identification Number (EIN)	Plan Number
!	!

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for the service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The CG Claim Office responsible for this Plan

The cost of the Plan is !

The Plan's fiscal year ends on !

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Discretionary Authority

The Plan Administrator delegates to CG the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to CG the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

SUMMARY PLAN DESCRIPTION

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated, is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service;
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute, or;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Funding

The method for funding the insured parts of the Plan is for the employer to pay premiums for the insurance benefits from the general assets of the employer's business, after any required contribution for the insurance benefits is obtained from the employees by payroll deduction. To the extent that the premiums paid exceed the final premium costs for any policy year, the excess will be returned to and retained by the employer and will not become an asset of the Plan. However, for the insured parts of the Plan which require employee contribution, to the extent such premium excess exceeds the employer's contributions for the insurance premiums, including the costs expended to administer the plan, that amount will be applied by the employer for the sole benefit of the employees.

SUMMARY PLAN DESCRIPTION

The Plan is handled by the Plan Administrator with benefits as set forth in the group insurance policies issued by CG.

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective-bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

SUMMARY PLAN DESCRIPTION

Continue Group Health Plan Coverage

- continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state for Federal court.

Enforce Your Rights

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining the documents form the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

CG will provide administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration.

Benefits provided under this certificate are fully guaranteed by CG.

This certificate is issued by:

Connecticut General Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

CLAIM DETERMINATION PROCEDURES UNDER ERISA

The following complies with federal law effective July 1, 2002. Provisions of the laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be medically necessary to be covered under the plan. The procedures for determining medical necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice medical necessity determination." The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request medical necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not medically necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents, and in the determination notices.

Preservice Medical Necessity Determinations

When you or your representative request a required medical necessity determination prior to care, CG will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond CG's control, CG will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to CG within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, CG will make the preservice determination on an expedited basis. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. CG will notify you or your representative of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, CG will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to CG within 48 hours after receiving the notice. CG will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow CG's procedures for requesting a required preservice medical necessity determination, CG will notify you or your representative of the failure and describe the proper procedures for filing within five days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This

notice may be provided orally, unless you or your representative requests written notification.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, CG will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

When you or your representative requests a medical necessity determination after services have been rendered, CG will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control CG will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

Postservice Medical Necessity Determinations (Continued)

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to CG within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

DEFINITIONS

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with CG for a different amount.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness. Custodial Services include, but shall not be 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 usually be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

DEFINITIONS

Dependent

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is
  - less than 19 years old;
  - 19 years but less than 25 years old, enrolled in school as a full-time student or on church missionary and primarily supported by you;
  - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child, including that child from the first day of placement in your home regardless of whether the adoption has become final. It also includes a stepchild who lives with you.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

Durable Medical Equipment

The term Durable Medical Equipment means equipment which:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is generally not useful to a person in the absence of Sickness or Injury; and
- is appropriate for use in the home.

Emergency Services/Emergency Medical Condition

Emergency Services are a health care item or service furnished or required to evaluate and treat an Emergency Medical Condition, which may include, but shall not be limited to health care services that are provided in a licensed Hospital's emergency facility by an appropriate provider. An Emergency Medical Condition is the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(1) placing the person's health in significant jeopardy;

(2) serious impairment to a bodily function;

(3) serious dysfunction of any bodily organ or part;

(4) inadequately controlled pain; or

(5) with respect to a pregnant woman who is having contractions:

  (a) that there is inadequate time to effect a safe transfer to another hospital before delivery; or

  (b) that transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are temporary or who normally work less than 20 hours a week for the Employer.

Employer

The term Employer means the Policyholder and all Affiliated Employers.

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Home Health Care Agency

The term Home Health Care Agency means a Hospital or a non-profit or public home health care agency which:

- primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Graduate Nurse;
- is run according to rules established by a group of professional persons;
- maintains clinical records on all patients;
- does not primarily provide custodial care or care and treatment of the mentally ill;

but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

Hospice Care Program

The term Hospice Care Program means:

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

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CG; and
- fulfills any licensing requirements of the state or locality in which it operates.

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals;
- a Free-standing Surgical Facility.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- an outpatient in a Hospital because of: (a) chemotherapy treatment; or (b) surgery;
- receiving emergency care in a Hospital for an Injury, on his first visit as an outpatient within 48 hours after the Injury is received;

The term Partially Confined means continually treated for at least 3 hours but not more than 12 hours in any 24-hour period.

Injury

The term Injury means an accidental bodily injury.

Late Entrant

You are a Late Entrant for Employee or Dependent Insurance if:

(a) you have not been continuously covered for one year under a group medical insurance policy or a self-insured group medical plan, other than a policy issued by a state high risk insurance pool; and

(b) you have declined medical coverage for yourself or your Dependents through your Employer during the initial enrollment period, or have ended your coverage at any time; and

(c) you later request coverage for yourself or your Dependents.

The initial enrollment period must have been at least 30 days. An individual is not considered a Late Entrant if one of the following applies:

1. The person, at the time of the initial enrollment period, was covered under a prior plan. “Prior plan” means a public or private group medical insurance policy or self-insured group medical plan.
2. The person lost coverage under the prior plan due to the Employee’s termination of employment or eligibility, the termination of the prior plan’s coverage, the death of the spouse, or divorce.
3. The person requests enrollment within 30 days after the termination of coverage provided under the prior plan.
4. The person is employed by an Employer that offers multiple medical plans and the person elects a different plan during an open enrollment period.
5. A court orders that coverage be provided for a spouse or minor child under a covered Employee’s medical plan and the Employee requests enrollment within 30 days after the court order is issued.

“Continuously covered” means the person is covered at the beginning and the end of the period and has not had any breaks in coverage during the period totaling more than 31 days.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Mental Illness

The term "mental illness" means any disorder, other than a disorder induced by alcohol or drug abuse, which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological symptoms related to a mental illness will not be considered to be charges made for treatment of a mental illness.

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Participating Provider

The term Participating Provider means:

- an institution, facility or agency which has entered into a contract with a Preferred Provider Organization (referred to as the PPO) to provide medical services at a predetermined cost in accordance with the agreement between CG and the PPO.
- a health care professional who has entered into a contract with a PPO to provide medical services at predetermined fees as negotiated by CG and that PPO.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by your Employer.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.

Reasonable and Customary Charge

A charge will be considered Reasonable and Customary if:

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CG.

To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

Sickness - For Medical Insurance

The term Sickness means a physical illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which is provided to treat a condition that is: (1) less severe than an Emergency Medical Condition; (2) requires immediate medical attention; and (3) is unforeseen.

Care which could have been foreseen as needed before leaving the provider network area where the insured ordinarily receives and/or was scheduled to receive services does not meet the definition of Urgent Care. Such foreseeable care includes, but is not limited to: delivery beyond the 35th week of pregnancy, dialysis, scheduled medical treatments or therapy, or care received after a Physician’s recommendation that the insured should not travel due to any medical condition.

EXHIBIT B-1

General Medical			
#	Issue	Response	
1	If the county carves out prescriptions and behavioral health, would you agree to participate in one ID card that will include the rx coinsurance and bh phone number? If so, would you agree to produce it? What impact does your response have on proposed rates?	CIGNA is unable to participate in a one ID Card, that will include third party rx coinsurance and bh phone number. Liability, production/vendor issues, formatting/space limitations, and service problems are the driving factors in precluding one id card.	Would CIGNA be willing to participate in a single I.D. Card if Maricopa County hired a vendor to produce the card? CIGNA would be willing to allow this contingent on the use of a delegation agreement to control the process as well as any other required documents needed to protect CIGNA, Maricopa County, and the member.
2	Please confirm you will at a minimum meet the countys onsite staffing request - 10/01 - 01/31/03 (10/hrs week - Oct; 5 hrs week November & December; 40 hrs. week for January)?	Yes	
3	Please confirm you will at a minimum meet thje countys ongoing Staffing Commitment - Ongoing (CIGNA now 10/hrs every other week)	Yes	
4	The county desires that you provide all your documents (written & electronic) in Spanish/English? Please identify any limitations that would prevent you from doing so on specific documents.	CIGNA is currently expanding it's selection of documentS that are in Spanish and English. Complete enrollment packets are now available in Spanish as well other marketing materials. Spanish enrollers and Member Services representatives are also available. However, it is not feasible to produce all documents in both languages. Limitations include the production, translation, maintenance, and filing of documents with the DOI that can not be specifically linked with a member. In other works, CIGNA does not know if a members primary language is English or Spanish.	
5	Please confirm your new ID cards for 2003 and beyond will differentiate products (member should know what product they are on)?	Yes, they will be labeled.	
6	Please confirm you will be able to provide Maricopa County Specific HEDIS data (plan/strategies to improve scores utilization for County)?	Yes	
7	Please confirm you will make all reasonable efforts to notify Maricopa County of changes in the network before they are communicated publically (press) and to the employees?	Yes	
8	Please confirm you agree up to two County specific annual claims audits by outside consulting company (2 audits per year?)	Based on a reasonable request, Maricopa County will be allowed the opportunity to a second audit should the results of the first audit be found unacceptable. For clarification, it will be the responsibility of Maricopa County to select and fund the outside consulting company.	
9	Please provide the date which you will guarantee SPD's will be completed for delivery to the county employees? What amount of liquidated damages are you willing to put at risk for meeting the proposed date?	CIGNA will put at stake liquidated damages of $15,000 for timely delivery of SPD's. The SPD's are a bi-product of entering eligibility and they are mailed directly to a members home. CIGNA will work with Maricopa County to mutually agree on a date. At this time, without an open enrollment schedule and deadline for submission of eligibility, it is premature to determine a date.	

10	Can you provide a year-end EOB (individual accounting of claims payments during year)?	At this time, CIGNA is unable to commit to this request. We are continuing to explore the possibility of performing this function locally.	
11	Would you agree to negotiate participation in the network of an independent PBM for CIGNA HMO pharmacies?	No	Clarification: Based on CIGNA's business model, we will not bound our physicians to prescribing to any formulary but our own for physician efficiency, member convenience, acquisition cost, and other market positioning reasons.
12	Confirm your agreement to participate in joint operating meetings with other vendors?	CIGNA is willing to meet with other vendors.	
13	If the county selects an independent behavioral health vendor, confirm your agreement to enter into good faith negotiation of a written agreement on how to process certain claims that have both a general medical and behavioral health component (medical stabilization, emergency transport, etc.)?	Yes	
14	If the county carves out prescriptions and behavioral health, confirm your good faith agreement to both initiate and participate in necessary triage calls among all 3 vendors as appropiate to ensure minimal disruption to members?	Due to confidentiality (current/future HIPPA privacy regulations) and associated liability issues, CIGNA will not share member specific information with a third party vendor.	Maricopa County & CIGNA Council discussing.
15	Confirm your agreement to allow Maricopa County to approve correspondence that goes out to all employees & dependents?	Yes	
16	Confirm your agreement to attend initial rollout meetings to elected officials, appointed, etc. (less than 5 meetings)?	Yes	
17	Confirm your agreement to participate in separate open enrollment meetings for retirees at appropriate geographic locations	Yes	
18	If the county carves out prescriptions and behavioral health date, would you agree to routine transmission eligibility and/or PCP selection data to the selected vendors on behalf of the county?	Due to confidentiality (current/future HIPPA privacy regulations) and associated liability issues, CIGNA will not share member specific information with a third party vendor.	Would CIGNA be willing to receive eligibility feeds from the County and how frequently could this occur? CIGNA can except automated eligibility on a weekly basis.
19	Confirm the county will receive routine electronic updates to the provider directory	Yes	

20	Provide a proposed plan design and rates for an out of area comprehensive plan which can be made available to dependents who reside outside of a CIGNA POS/PPO service area.	CIGNA does not offer a product that covers dependents independently from the employee. However, we do have several options available that would provide coverage to dependents in most situations. If a dependent is residing outside the Maricopa County service area, but in a location that CIGNA has an HMO/POS network, they can use our Guest Privilege program (Employees must be enrolled in HMO or POS for their dependents to be eligible for Guest Privileges). If a employee is enrolled in the PPO program, and a dependent resides outside of our nation wide PPO network, they can use the out of network benefits. Note: CIGNA's PPO network is extensive.	
21	Do you agree to provideMonthly/Quarterly Utilization Data by 15th of the following month - complete with analysis, strategies and ways to improve quality initiatives (Year to date) - broken down by age, gender, type service, product etc.	At this time, CIGNA is unable to commit to delivering reports by the 15th. Utilization reports containing the data shown in Exhibit H of the proposal will be delivered no later than 31 days following the end of a given quarter. Strategies and quality initiatives will be provided. Reports will be broken out by product.	
22	Do you agree to perform provider profiling and analysis and share that information with the county?	CIGNA will share our efforts regarding provider profiling but due to confidentiality / proprietary information, we will be unable to share specific provider information.	
23	Would you agree to provide clinical data on specified conditions to RX & BH vendor for the purposes of outreach and disease management initiatives?	Due to confidentiality (current/future HIPPA privacy regulations) and associated liability issues, CIGNA will not share member specific information with a third party vendor.	Maricopa County & CIGNA Council discussing.
24	Do you agree to a dedicated Claims Processing Unit?	All Claims will be processed in our Sherman Claim Office.	
25	Do you agree to a dedicated Customer Service Unit - Open Enrollment& ongoing? (Team of people)	The Member Services department in Sherman will be the dedicated customer service unit. In the event of heavy call volume it is CIGNA's practice to load balance calls to another location.	Clarification: While customer service personnel will be familiar with Maricopa County, we will assign 1 or more Supervisory level representatives as resources should questions arise.
26	Will you agree to provide Welcome Calls to new PPO and Retiree members to ensure they fully understand the plan of benefits	CIGNA proposes this be done by the on site staff supplied by CIGNA during open enrollment and in the month of January.	Clarification: CIGNA agrees to this request.
27	Will you agree in writing to provide coverage for Missionaries?	Yes	

28	With respect to the GSA, will you agree to the following provisions: Page - 3 Disenrollment time frame - 90 days; Page - 3 HIPAA Certificates of Coverage to be provided at no additional charge; Page - 3 Payment method for group may remain on current 26 pay period basis; Pages 30-32 Enrollment and effective date of coverage, Full-time students covered to age 25; Page 45-54 Covered services and supplies, Vision is not currently a covered service and if the County carves out behavioral health it will not be covered either; Pages 55-57, exlusions and limitations, the County would like to delete the exclusions for treatment of an illness or injury, which is due to war, declared or undeclared.	Yes to all with the following notes: The reference made in the Group Service Agreement to Vision and Behavioral Health will remain. The narratives regarding these services do not list specific benefits but rather define the type of service. Even if Behavioral Health is carved out, a detoxification benefit will apply, and vision screenings can be done ap part of a physical exam. CIGNA's will remove the War exclusion.	CIGNA aggress to remove/clarify verbiage in the Group Service Agreement as allowed by the State of Arizona. The time it takes to get such changes approved is entirely up to the Department of Insurance. Approvals can happen in a matter of weeks to several months. Clarification: During the meeting held on 7/2/02, a question was asked regarding Section VIII: Payments, in particular the verbiage about limit to Copayments. The Group Service Agreement that will go into effect 1/1/03, no longer words the Out of Packet Maximums (OOP) this way. In the current environment the OOP is listed on the Face Sheet. In 2003, the OOP is listed in a Schedule of Copayments included in the GSA and no longer on the Face Sheet.
29	Confirm your agreement to good faith negotiation of contract terms and conditions with County counsul, material management and risk management departments.	Yes	
30	Recognizing that the county must have firm fixed rates to enter into a fully insured contract with CIGNA, please remove rate conditions on demographic enrollment in the PPO and contribution changes. The county agrees that it will not reduce the current county contribution more than 20 percentage points below the current 93% employee/ 73% dependent contribution toward the POS plan without a rerate and that it is not looking to artificially create incentives for employees to enroll in any specific option through variances in county contributions between options.	See response to questions #34, as it appears to be essentially the same question.	
31	Will you agree to monitor Maricopa County specific claim standards and provide case specific reporting for turnaround time and accuracy for performance standard purposes? Will you agree that if a statistically valid independent audit is performed, such results will be used for monitoring performance standards in the period audited?	CIGNA will track POS/PPO out of network turn around times specific to Maricopa County. All other measures will be tracked on a claim office level. CIGNA requires that a consistent measurement be used regarding performance guarantee payouts. Because of practice and measurement variations among independent auditors, it is CIGNA's firm policy not us use results from third party audits to measure PG payouts.	Position remains the same.

32	If we carve out Behavioral Health, will CIGNA provide BH vendor notification of breast cancer and cardiac patients and other chronic medical conditions with a high incidence of co-occurring depression and anxiety	Due to confidentiality (current/future HIPPA privacy regulations) and associated liability issues, CIGNA will not share member specific information with a third party vendor.	Maricopa County & CIGNA Council discussing.
33	If we carve out prescription benefits, will CIGNA consider excluding self-injectible drugs from coverage? If so, what rate credit will you grant the county.	Many self-injectible drugs are already covered under CIGNA's pharmacy benefit (I.E. Glucagon, Imitrex, Insulin). Most injectible supplied/administered by a doctor are covered under the medical plan. There would be no measurable impact to credit the medical rates.	
34	Recognizing that the county must have firm fixed rates to enter into a fully insured contract with CIGNA, please remove rate conditions on demographic enrollment in the PPO and contribution changes. The county agrees that it will not reduce the current county contribution more than 20 percentage points below the current 93% employee contribution and 73% dependent contribution for the POS plan without providing CIGNA the opportunity to rerate. The county intends for employees to pay the difference in rates between plans as long as such rates reasonably reflect the difference in the value of the plans.	We will remove the requirement.	
35	After careful review of CIGNA Arizona 2000 HEDIS results and national average performance as reported in 2001 Quality Compass prepared by the NCQA it was determined that the performance standards listed in the RFP are reasonable and any reduction in standards would result in the potential deterioration of service levels county employees already received during the 2000 plan year. Standard 1.6.8 is clarified to be the rate of diabetic eye exams. As no specific penalty is associated with failure to meet such standards we do not believe CIGNA has any significant risk in the counties maintenance of the requested standards. Confirm your understanding that the performance incentive payment standards listed in the RFP will apply as are to the HMO and POS plans.	CIGNA understands there is no specific penalty for not meeting the standards listed. We do maintain that based on the requirements listed, even with our best efforts, it will not be possible to satisfy a minimum of 9 criteria.	

36	Does CIGNA agree to include de-identified large claimant data (>$25,000) to the county on a quarterly basis by identified sub-group of county employees (I.e. MIHS, other specified departments) Confirm de-identified large claimant information will include dollar amounts, dates incurred, age, gender, department, and primary diagnosis.	Large claim information will include relationship (Employee, child, or spouse), dollar amount, major diagnostic group and minor diagnostic group. De-identified large claim information will be sub-group.	Clarification: Large Claim information will be provided quarterly.
37	Will CIGNA agree to develop a county specific web-site that includes only county specific information on plan design, medical management protocol, network data? Will such data be updated at least bi-monthly?	While CIGNA is unable to develop a County specific web-site, we will work with the benefits staff to maintain, review, and update information posted on the County Intranet. In addition, we anticipate the member self-service capabilities that will come from our partnership with Yahoo will allow much of this information. Target date, first quarter 2003.	
38	Does CIGNA have an on-line eligibility processing and reporting capability at no additional cost?	At this time CIGNA anticipates having on-line eligibility capabilities available sometime 1st quarter 2003. No associated costs to customers have been identified at this time.	Clarification: There will be no cost to Maricopa County to have a station set up in the benefits office once available.
39	What rate change will apply if we eliminate the separate hospital copay from the POS and PPO plans	Eliminate POS Hospital Copay = +1.5% to rates, PPO = +2.5% to rates	Eliminate POS Hospital Copay = +0.5% to rates, PPO = +0.7% to rates
40	Please review the attached analysis of your current physical therapy delivery model and determine if you be willing to make the modifications suggested by the county. If so, what, if any rate impact would this have?	The model and recommendations are still in review by the Healthplan.	CIGNA feels it would be difficult to implement the proposed therapy model on a managed care program. The recommendations made seemed to be based heavily on Worker Compensation and some Disability programs where employees are mandated to specific treatment protocols. The vast majority of therapy CIGNA members would see their primary care physicians would be for non-occupational injuries were it would be difficult to mandate participation in a therapy program and share condition status with an employer.
41	CIGNA IPA and PPO physicians currently charge employees to complete Department of Labor FLMA forms. Will CIGNA consider modifying its contracts such that employees can not be charged more than the office visit copayment for completion of such forms?	CIGNA will need more information from Maricopa County regarding this matter prior to making a decision. For example, how many members apply for FLMA, what are they being charged, is every doctor charging the same amount? If doctors are charging for this today, CIGNA would have to reimburse through a fee schedule. A contract negotiation would need to be substantiated and justified prior to commitment.	CIGNA is in the process of gathering any available data regarding this matter. We need to learn why some doctors are charging up to $100 to complete FLMA forms, while others are charging much less. We will use our resources and work with Maricopa County to develop a solution to this issue.

42	The county has reviewed the incurred loss ratio report for the 2001 calendar year plan, as well as a comparison of the first quarter 2002 to 2001. This data was not available at the time of the initial bid, and we believe it indicates that CIGNA may be able to reduce its quoted rate for general medical coverage. Please review this data and provide best and final general medical pricing for purposes of this proposal. The counties consultant has recommended that any reduction should first be applied to the POS plan (up to 6%) with the remainder of the reduction applied to all plans equally.	See Attached.	
43	The county does not agree to the accounting principal for payment described in the Face Sheet based on the section that describes the 15th of the month.	CIGNA will reconcile the account based on County policy. This will require a work around as our systems do not pro-rate premium based on begin or end date.	
44	Confirm that Authorization is not required to use the Alternative Medicine benefit.	Confirmed. A member can self-refer up to 6 visits without a referral or authorization for the services covered under the benefit.	
45	Confirm CIGNA accepts the following eligibility policy for new hires: Benefits will start the first pay period following 14 days after completed forms are submitted. Employees have 60 days from hire date to submit completed forms.	Confirmed.	
46	Clarify what benefits cross accumulate on the POS and PPO.	The Life Time Maximum, Outpatient Rehabilitation Visits, Skilled Nursing Days, and Home HealthCare days all cross accumulate.	
47	What is the difference between a Periodic Health Exam and an Physical Exam? Can a member have a Physical Exam every year?	The Periodic Health Exam includes Vision and Hearing screenings. These are separated from a physical exam because they are typically not medically necessary ever year. Yes, member is entitled to a physical exam every year.	
48	Why are the pre 65 and post 65 rates the same?	These rates are blended for ease of administration and taking into dependent age may vary from employee.	

EXHIBIT B-2

	A. HMO	B. POS		C. PPO	
	In-Network	In-Network	Out-of Network	In-Network	Out-of Network
Standard Benefit Coverage					
Deductible					
Individual	None	None	$300	$250	$750
Family	None	None	$600	$500	$1,500
Standard Coinsurance Percentage	100%	100%	70%	80%	60%
Coinsurance on Next $ x,xxx Covered Expenses (then 100%)					
Individual	$1,000 OOP Max	$1,000 OOP Max	$3,000 OOP Max	$2,000 OOP Max	$4,000 OOP Max
Family	$2,000 OOP Max	$2,000 OOP Max	$6,000 OOP Max	$6,000 OOP Max	$12,000 OOP Max
Lifetime Maximum Benefit	Unlimited	Unlimited	$5,000,000	Unlimited	$5,000,000
Pre-existing Conditions	None	None	12 Months Coverage, waived if covered 1/01/03	None	12 Months Coverage, waived if covered 1/01/03
General Services					
Preventive Care	$10 Copay	$15 Copay	Covered In-Network Only	$20 Copay	Covered In-Network Only
Primary Care Physician Services	$10 Copay	$15 Copay	70%	$20 Copay	60%
Specialty Care Physician Services	$10 Copay	$25 Copay	70%	$30 Copay	60%
Urgent Care (Participating)	$35 Copay	$50 Copay	70%	$50 Copay	70%
Outpatient Lab and X-Ray	$0 lab or X-Ray $50 for MRI & CAT	$0 lab or X-Ray $50 for MRI & CAT	70%	80% Coinsurance	60%

Inpatient Coverage					
Facility Charges	No Copay	$100 Copay	70% (Precertification Required)*	80%	60% (Precertification Required)*
Physician & Surgeon's Services	No Copay	No Copay	70% (Precertification Required)*	80%	60% (Precertification Required)*
Outpatient Surgery	No Copay	$50 Copay	70% (Precertification Required Over $500)*	80%	60% (Precertification Required Over $500)*
Precertification Penalty*	NA	NA	$400	$400 / ~~NA~~	$400
Maternity					
Pre & Postnatal Exams(after pregnancy has been determined)	Copay waived after 1st visit	Copay waived after 1st visit	70%	Copay waived after 1st visit	60%
Delivery	Copay waived	$100 In-Patient Copay	70%	80%	60%
Emergency Care (Defined by Plan)					
Emergency Room	$75 Copay	$100 Copay	$100 Copay if emergency, otherwise 70%	$100 Copay	100 Copay if emergency, otherwise 60%
Ambulance	No Copay	No Copay	No Copay	90%	90%
Equipment and Devices					
Durable Medical Equipment	No Copay (CIGNA requires $3500 Max)	No Copay (CIGNA requires $3500 Max)	Covered In-Network Only	80% ($700 max.)	60% ($700 max.)
External Prosthetics, Orthotics and Colostomy Bags	*No Copay ($1000 Max)*	*No Copay ($1000 Max)*	Covered In-Network Only	80% ($200 ded., $1,000 max.)	60% ($200 ded., $1000 max.)
Outpatient Rehabilitation					
Physical, Speech, and Occupational Therapy Subscriber Payment	*$10 Copay*	*$10 Copay*	70%, Chiropractic Covered In-Network Only	$20 Copay	60%

Limit	60 Visits	60 visits combined		60 visits combined	
Ancillary Benefits					
Vision	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Exam	$10 Copay	$15 Copay	Not Covered	$20 Copay	Not Covered
Other Healthcare Facilities					
Skilled Nursing Facilities					
Subscriber Payment	No Copay	No Copay	70%	80%	60%
Limit per Contract Year	*90 Days Combined*	*90 Days Combined*	*90 Days Combined*	90 Days Combined	90 Days Combined
Home Health Care	No Copay when medically necessary (Unlimited)	No Copay when medically necessary (Unlimited)	70% up to 40 Days per Year	80% (Unlimited)	60% up to 40 Days per Year
Family Planning					
Sterilization					
Vasectomy	Place of Service Copay	Place of Service Copay	70%	80%	60%
Tubal Ligation	Place of Service Copay	Place of Service Copay	70%	80%	60%
Infertility Treatment	Diagnostic Services and Corrective Treatment Only	Diagnostic Services and Corrective Treatment Only	Covered In-Network Only	Diagnostic Services and Corrective Treatment Only	Covered In-Network Only
Dependent Children					
Unmarried and legally dependent upon employee and/or spouse	Covered to Age 19 Unless Full Time Student and Then Covered to Age 25-(Includes Missionaries)	Covered to Age 19 Unless Full Time Student and Then Covered to Age 25 (Includes Missionaries)		Covered to Age 19 Unless Full Time Student and Then Covered to Age 25 (Includes Missionaries)	

Note: Lifetime Maximum and Visits per year for Out of Network Services, cross-accumulates with In-Network.
The detailed benefit summaries provide a more comprehensive summary of benefits.
Revised 7/8/2002

EXHIBIT B 3
CHMO PERFORMANCE GUARANTEE AGREEMENT

This Agreement is between CHC of Arizona, a CIGNA Company ("CIGNA"), and Maricopa County (the "Company").

In connection with the services CIGNA will provide to the Company with respect to the employee welfare benefit plan sponsored by the Company (the "Plan"), CIGNA and the Company desire to implement performance guarantees according to the terms set forth below, effective as of January 1, 2003 (the "Effective Date") and only for the Commercial HMO and POS medical coverage.

Section 1. Term

The term of this Agreement shall be from the Effective Date through the last day of the twelfth (12th) consecutive month following the Effective Date (the "Term").

Section 2. Conditions Precedent

The Company acknowledges and agrees that the conditions precedent to the effectiveness of this Agreement are as follows:

A. **General**

1. The number of enrolled employees in the portion of the Plan administered by CIGNA will exceed 499.

2. Where the Company or a third party is responsible for providing eligibility information or data of any kind to CIGNA, including but not limited to electronic data, tapes or software, the data is accurate and accessible.

Section 3. Implementation Performance Commitments and Penalty Amounts

In connection with the services CIGNA will provide to the Company with respect to the Plan, CIGNA guarantees its performance as stated below. (A summary of all performance commitments and their associated penalties is attached as Exhibit A).

A. **Call Readiness Performance Commitment.** The Plan specifications shall be loaded into the applicable inquiry system with the service centers ready to respond to customer inquiries as of the Effective Date.

The penalty for CIGNA's failure to meet the Claim Readiness Performance Commitment shall be the amount set forth in Exhibit A.

B. **Identification Card Delivery Performance Commitment.** A designated percentage of identification cards, as set forth in Exhibit A, for all eligible participants under the Plan for whom complete and accurate eligibility information has been received shall be mailed no later than the date set forth in Exhibit A.

The penalty for CIGNA's failure to meet the Identification Card Delivery Performance Commitment shall be the amount set forth in Exhibit A.

Section 4. Ongoing Performance Commitments and Penalty Amounts

A. **Telephone Services**

1. **Telephone Services Performance Commitments**

CIGNA makes the following commitments with respect to its customer service call or claim centers servicing the Company (“Call Centers”):

(a) **Average Speed of Answer Commitment.** The average speed to answer a phone call to a Call Center during the Term ("ASA") shall be no longer than the number of seconds designated in Exhibit A.

(b) **Telephone Abandonment Rate Commitment**. The percentage of calls received by the Call Center resulting in the caller terminating the call before speaking with a customer service representative (the "Abandonment Rate") shall, on average, be no greater than the percentage designated in Exhibit A.

2. **Evaluation of ASA and Abandonment Rate**

(a) The ASA will be determined by measuring the sum of the total elapsed time between the moment when telephone callers to Call Centers select to speak with a customer service representative and the time the callers are connected with a customer service representative, and dividing that number by the total number of telephone calls answered by the Call Centers during the Term.

(b) Abandonment Rate will be measured by dividing the total number of calls received by each Call Center during the Term that result in the caller terminating the call before speaking to a customer service representative by the total number of telephone calls received by the Call Centers during the Term, and expressing that number as a percent.

(c) ASA and Abandonment Rate will each be calculated automatically by the automatic telephone call distribution system used by each Call Center.

(d) The calculation of ASA and Abandonment Rate will be based on all telephone calls answered or received by the Call Centers and not solely on telephone calls relating to services provided by CIGNA to the Plan.

3. **Telephone Services Penalties**

(a) **Telephone Average Speed to Answer Penalty.** The penalty for CIGNA's failure to meet the Telephone Average Speed to Answer Performance Commitment shall be shall be the amount shown in Exhibit A.

(b) **Telephone Abandonment Penalty.** The penalty for CIGNA's failure to meet the Telephone Abandonment Performance Commitment shall be shall be the amount shown in Exhibit A.

B. **Account Management**

1. **Account Management Commitment**. CIGNA’s Account Management Team commits to provide services to the Company of such quality as will result in CIGNA's achieving the Account Management Composite Score designated in Exhibit A on the Account Management Report Card. The Account Management Report Card is attached as Exhibit D to this Agreement and will be completed by the Company on a quarterly basis.

2. **Evaluation of Account Management**

(a) At the beginning of the Term, the Company shall designate individuals on its benefits staff who will receive and complete the Account Management Report Card on a quarterly basis.

(b) The Account Management Report Card will be distributed to the Company’s designated staff members on a quarterly basis and shall be completed and returned to CIGNA by the Company within three weeks of its distribution date. The failure of the Company to satisfy this condition shall nullify the Account Management Commitment.

(c) Following the end of the Term and receipt of the 4th quarterly survey from the Company, CIGNA will calculate the Composite Score in each performance assessment category by averaging the scores for the four quarters of the Term. The assessments of each of the designated staff members and each of the performance assessment categories will be weighted equally. The Account Management Commitment will be deemed as fulfilled if the average of the Composite Scores in each category (the "Account Management Composite Score") is equal to or greater than the Account Management Composite Score indicated on Exhibit A.

(d) CIGNA reserves the right to make changes in the staff/personnel assigned to an account during the Term.

3. **Account Management Penalty**. The penalty for CIGNA's failure to meet the Account Management Commitment shall be the amount shown in Exhibit A.

Section 5. Weighting of Performance Results

A. **Weighting of Results for Telephone Services**. When more than one Inquiry Center is assigned to handle member inquiries, results for Telephone Services from each assigned Inquiry Center will be weighted equally in order to calculate the overall result.

A. Section 6. Evaluation of Services and Payment of Penalties

A. Within four (4) months after the end of the Term, CIGNA shall compile the necessary documentation and perform the necessary calculations to evaluate its fulfillment of each performance commitment set forth in this Agreement and make this information available to the Company.

B. Any dispute with the amount CIGNA determines to be owed under this Agreement must be raised in writing within sixty (60) days of the date CIGNA notifies the Company in writing of its determination.

C. If CIGNA fails to meet any of the performance commitments set forth in Section 3, CIGNA shall pay to the Company the appropriate financial penalty set forth in Exhibit A.

D. The total amount payable by CIGNA during the Term for failure to meet the performance commitments set forth in this Agreement shall not exceed the sum of the penalties associated with each performance commitment, that amount being $42,002

Section 7. Change in Reporting Format or Measurement

CIGNA reserves the right to replace or modify any performance commitment if necessitated by a change in circumstances that would cause the performance commitment to be an inaccurate or unfair method of measuring CIGNA's performance. In such event, the performance commitment will be modified to the degree necessary to carry out the intent of the parties.

Section 8. Setoff

CIGNA shall be entitled to setoff any amount owed by CIGNA to the Company under this Agreement against any debt owed by the Company to CIGNA, whether now existing or hereafter arising.

Section 9. Modification of Agreement

This Agreement constitutes the entire contract between the parties relating to the subject matter herein, and no modification or amendment hereto shall be valid unless in writing and signed by an officer of the Company and/or CIGNA's Regional Financial Officer.

Section 10. Termination of Agreement

A. This Agreement shall terminate upon the earliest of the following dates:

1. The end of the Term;

2. The effective date of any state's or other jurisdiction's action which prohibits activities of the parties under this Agreement;

3. the date upon which the Company either fails to meet its obligation to sufficiently fund the bank account from which claims are paid (if applicable), or fails to pay any premium charges, fees or other charges within the time frame specified in the applicable contract;

4. the date upon which the contract under which CIGNA provides services to the Company is terminated;

5. the date upon which any condition precedent set forth in Section 2 is not fulfilled; or

6. any other date mutually agreeable to the Company and CIGNA

Section 11. Laws Governing Contract

This Agreement shall be governed by and construed in accordance with the laws of the State of Arizona.

Section 12. Resolution of Disputes - Arbitration

It is understood and agreed that any dispute, controversy or question arising under this Agreement shall be referred for decision by arbitration in Hartford, Connecticut by an arbitrator selected by the parties. The proceeding shall be governed by the Rules of the American Arbitration Association then in effect or such rules last in effect (in the event such Association is no longer in existence). If the parties are unable to agree upon such an arbitrator within thirty (30) calendar days after either party has given the other party written notice of its desire to submit the dispute, controversy or question for decision, then either party may apply to the American Arbitration Association for the appointment of an arbitrator or, if such Association is not then in existence or does not desire to act in the matter, each party shall appoint an arbitrator of its choice. The appointed arbitrators will select a third arbitrator to hear the parties and settle the dispute, controversy or question. The compensation and expenses of the arbitrator(s) and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by the parties.

Arbitration shall be the exclusive remedy for the settlement of disputes arising under this Agreement. The decision of the arbitrator(s) shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator(s).

This provision shall survive the termination of this Agreement.

Section 13. Third Party Beneficiaries

This Agreement is for the benefit of the Company and CIGNA and not for any other person. It shall not create any legal relationship between CIGNA and any employee, beneficiary or any other party claiming any right, whether legal or equitable, under the terms of this Agreement or the Plan.

Section 14. Waivers

No course of dealing or failure of either party to strictly enforce any term, right or condition of this Agreement shall be construed as a general waiver or relinquishment of such term, right or condition. Waiver by either party of any default shall not be deemed a waiver of any other default.

Section 15. Force Majeure

CIGNA shall not be liable for any failure to meet any of the obligations specified or required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of CIGNA, its employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or reasonably controlled by CIGNA, its employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations, whether valid or invalid.

Section 16. Survival

Provisions contained in this Agreement that by their sense and context are intended to survive completion of performance, termination or cancellation of this Agreement shall so survive.

Section 17. Notices

Except as otherwise provided in this Agreement, all notices or other communications hereunder shall be deemed to have been duly given when made in writing and either a) delivered in person, b) delivered to an agent, such as an overnight or similar delivery service, or c) deposited in the United States mail, postage prepaid, and addressed as follows:

To CIGNA:
11001 N. Black Canyon Hwy, 4th floor
Phoenix, AZ 85029
Attention: Tim Thomas (Client Manager)

To the Company:
Maricopa County
320 W. Lincoln Street
Phoenix, AZ 85003
Attention: Materials Management

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in duplicate and signed by their respective officers duly authorized to do so as of the first date written above.

CIGNA HealthCare of Arizona

By:_____

Title: __General Manager____

Date:_____ (required)

Maricopa County

By: _____

Title: _____

Date: _____ (required)

EXHIBIT A

PERFORMANCE COMMITMENTS AND PENALTIES – CHMO MEDICAL BENEFITS

Performance Category	**Performance Commitment**	**Penalty Amount**
Identification Card Delivery Performance Standard	98 % of Identification cards mailed no later than *Date December 24, 2003*	**$20,000**
Call Readiness Performance Commitment	Inquiry centers ready to respond to customer inquiries as of Plan effective date.	**$7,334**
Telephone Services **-Average Speed of Answer ("ASA")** -Call Abandonment Rate	Average Inquiry Site results will not exceed: -45 seconds to answer a phone call -5% of calls received by Call Center(s) terminated	**$7,334**
Account Management	Account Management Composite Score (all categories) of 3.0 or better on the Account Management Report Card based on four (4) quarterly assessments.	**$7,334**
	Total Financial Commitment	**$42,002**

CHC of Arizona

Client Name: _Maricopa County_____ Lead Claim Office: _____
Account Number: _3205496_____ Sales Office/Routing #: __Phoenix/397

Contract Term: From 01/01/2003 to12 /31 /2003 Sales Representative: Tim Thomas_____

Projected # of Enrolled Employee Lives: 8372___ Underwriter Approval By: _Susan Pak____

Implementation Calendar
Effective Date: 01.01.03

EXHIBIT B

IMPLEMENTATION CALENDAR

Task	Responsible	Start Date	Target Completion Date	Actual Completion Date
Introduce Implementation Team to Maricopa County; discuss benefits, reporting, structure, billing, eligibility, pre- and post-enrollment materials, claim forms, ID cards and claim requirements	CIGNA, Maricopa County	9/11/02	9/11/02	9/11/02
Confirm Maricopa County's approval of structure, benefit summary, sample bill, eligibility and overall implementation strategy as outlined in the Implementation Guide	CIGNA	9/12/02	9/25/02	
Meet with Eligibility Services to review automated eligibility tape requirements	Maricopa County, CIGNA	9/23/02	10/4/02	
Provide structure codes to Maricopa County for coding of enrollment forms	CIGNA	9/26/02	10/1/02	
Internal CIGNA Expert Team meeting to review account requirements	CIGNA	9/27/02	10/4/02	
Load account structure & benefits into CIGNA systems	CIGNA	10/4/02	11/1/02	
ID cards and claim forms ordered	CIGNA	9/26/02	10/4/02	
Open enrollment period for Maricopa County	Maricopa County, CIGNA	10/12/02	11/3/02	
Submit automated eligibility test tape	Maricopa County	11/5/02	11/5/02	
Process automated test tape and report results to client	CIGNA	11/6/02	11/12/02	
Submit automated eligibility production tape *	Maricopa County	12/5/02	12/5/02	

Task	Responsible	Start Date	Target Completion Date	Actual Completion Date
Collect and distribute enrollment forms to appropriate areas for manual eligibility loading* **(changes for COBRA & Retirees)**	Maricopa County, CIGNA	11/4/02	12/5/02	
Eligibility loaded into CED	CIGNA	12/6/02	12/18/02	
Release ID card production feed	CIGNA	12/18/02	12/18/02	
ID cards and post-enrollment collateral materials mailed	CIGNA	12/19/02	12/24/02	
Mail first bill	CIGNA	12/30/02	12/31/02	
Conduct wrap-up meeting regarding implementation	CIGNA, Maricopa County	1/30/03	1/31/03	

*Performance guarantee commitment and penalty amounts are subject to receipt of usable and complete eligibility information by the date listed.

The dates included in this Implementation Calendar are subject to change. If a change is necessary, CIGNA will work with you to reach a new agreement that reflects the changes in circumstances.

The term "CIGNA" refers to the various entities, which will provide the coverage and/or services described, including, but not limited to, Connecticut General Life Insurance Company, CIGNA HealthCare, CIGNA Dental Health, Intracorp, and CIGNA Behavioral Health.

EXHIBIT D

ACCOUNT MANAGEMENT REPORT CARD

Rating Methodology:
5 = Completely Satisfied
4 = Very Satisfied
3 = Satisfied
2 = Somewhat Satisfied
1 = Dissatisfied

Client/Company Name: _Maricopa County_____
Completed By (please print): _____
Telephone #: _____

At the end of each quarterly period, please complete the box with the score that most closely reflects your level of satisfaction with the local account management team with respect to the following service categories:

Measurable Need	**1st Q**	**2nd Q**	**3rd Q**	**4th Q**	**Composite Score**
Delivers agreed upon reports and communication of CIGNA results on time. Delivery of Quarterly Utilization Reports					

Fill in for each quarterly period:
Date Sent to Client: __/ /__ __/ /__ __/ /__ __/ /__
Date Returned by Client: __/ /__ __/ /__ __/ /__ __/ /__

If you rated any of the above categories less than "Satisfied" (3), please tell us why:

X 1st Q:

X 2nd Q:

X 3rd Q:

End of Year Comments:

Please return this form to: _____

EXHIBIT B-4
PERFORMANCE GUARANTEE AGREEMENT FOR CIGNA'S ANNUAL SERVICE METRICS

This Agreement is between Connecticut General Life Insurance Company, a CIGNA Company ("CIGNA"), and Maricopa County(the "Company").

In connection with the services CIGNA will provide to the Company with respect to the employee welfare benefit plan sponsored by the Company (the "Plan"), CIGNA and the Company desire to implement performance guarantees according to the terms set forth below, effective as of January 1, 2003 (the "Effective Date") for the following products:

(Check which products the guarantee applies to)
Medical:
[X] Indemnity/PPO/PPA

Section 1. Term

The term of this Agreement shall be from the Effective Date through the last day of the twelfth (12th) consecutive month following the Effective Date (the "Term"). Providing this Agreement is executed prior to the Effective Date, CIGNA's fulfillment of the performance commitments set forth in this Agreement shall be measured from the Effective Date.

In the event that it is not executed prior to the Effective Date, CIGNA's performance shall be measured from the first day of the month following the month this Agreement is executed, or, if this Agreement is not executed before the sixteenth (16th) of the month, from the first day of the second month following the month this Agreement is executed.

Section 2. Conditions Precedent

The Company acknowledges and agrees that the conditions precedent to the effectiveness of this Agreement are as follows:

A. Both parties must sign this Agreement no later than three (3) months following the Effective Date.

B. The benefits offered under the Plan, including both design and structure (the "Benefit Profile"), have been finalized and approved by the Company and CIGNA prior to the Effective Date.

C. The number of enrolled employees in that portion of the Plan that is administered by CIGNA exceeds 499 on the Effective Date.

D. Where the Company or a third party is responsible for providing eligibility information or data of any kind to CIGNA, including but not limited to electronic data, tapes or software, the data is accurate, accessible and received by CIGNA within the predetermined timelines.

Section 3. Performance Commitments and Penalty Amounts

In connection with the services CIGNA will provide to the Company with respect to the Plan, CIGNA guarantees its performance as stated below. (A summary of all performance commitments and their associated penalties is attached as Exhibit A).

A. Time to Process

1. **14 Day Time-to-Process Performance Commitment.** CIGNA shall process a designated percentage of Clean Claims it receives in connection with the Plan during the Term within fourteen (14) calendar days, as calculated under the Time-to-Process Formula set forth below. The designated percentage is shown in Exhibit A.

2. **Time-to-Process Results Measurement**

   (a) The calculation of the time to process claims ("Time-to-Process") will be account-specific.

   (b) "Clean Claims" are claims that are capable of being either automatically adjudicated or otherwise processed during the initial review by the claims processor.

   (c) A claim is "processed" when a payment, a denial of benefits or an explanation of benefits is issued to the claimant or the provider.

   (d) Time-to-Process will be calculated by counting the number of calendar days from the day that the claim is received by CIGNA to and including the day the claim is processed. The calendar day that the claim is received will not be included in this calculation.

3. **14 Day Time-to-Process Penalty.** The penalty for CIGNA's failure to meet the 14 Day Time-to-Process Performance Commitment shall be the amount shown in Exhibit A.

B. Financial Accuracy

1. **Financial Accuracy Performance Commitment.** The Service Center(s) servicing the Company (the "Service Center(s)") shall correctly pay a designated percentage of the total dollars paid for all accounts in connection with the same product(s) that are provided by CIGNA to the Company and serviced by the Service Center(s) during the Term. The designated percentage is shown in Exhibit A.

2. **Evaluation of Financial Accuracy**

   Fulfillment of the Financial Accuracy Performance Commitment set forth above ("Financial Accuracy") will be determined as follows:

   (a) Data used to determine Financial Accuracy will be comprised of the claims audited for all accounts in the course of routine claim audits conducted by each Service Center during the Term.

   (b) Financial Accuracy will be measured by subtracting the sum of the total dollars overpaid and the total dollars underpaid (without offsetting one against the other) from the total dollars paid and dividing that amount by the total dollars paid.

   (c) The formula for calculating Claim Processing Accuracy will be the total number of claims processed without any errors, divided by the total claims processed, expressed as a percent.

3. **Financial Accuracy Penalty.** The penalty for CIGNA's failure to meet the Financial Accuracy Performance Commitment shall be the amount shown in Exhibit A.

C. Claim Processing Accuracy

1. **Claim Processing Accuracy Performance Commitment.** The Service Center(s) shall accurately process a designated percentage of the total claims processed for all accounts serviced by the Service Center(s) during the Term. The designated percentage is shown in Exhibit A.

2. **Evaluation of Claim Processing Accuracy**

Fulfillment of the Claim Processing Accuracy Performance Commitment set forth above ("Claim Processing Accuracy") will be determined as follows:

(a) Data used to calculate Claim Processing Accuracy will be comprised of all claim processing entries on the claims processing system, for all accounts in connection with those products that are provided by CIGNA to the Company, whether or not they have a financial impact on the claims processed, including but not limited to procedural and coding entries.

(b) Data used to determine Claim Processing Accuracy will be comprised of the claims audited for all accounts in the course of routine claim audits conducted by each Service Center(s) during the Term.

(c) The formula for calculating Claim Processing Accuracy will be the total number of claims processed without any errors, divided by the total claims processed, expressed as a percent.

3. **Claim Processing Accuracy Penalty.** The penalty for CIGNA's failure to meet the Claim Processing Performance Commitment shall be the amount shown in Exhibit A.

D. Telephone Services

1. **Telephone Services Performance Commitments**

CIGNA makes the following commitments with respect to its Customer Service Centers servicing the Company ("Service Centers"):

(a) **Average Speed of Answer Commitment.** The average speed to answer a phone call to a Service Center during the Term ("ASA") shall be no longer than the number of seconds designated in Exhibit A.

(b) **Telephone Abandonment Commitment**. The percentage of calls received by the Service Center resulting in the caller terminating the call before speaking with a customer service representative (the "Abandonment Rate") shall, on average, be no greater than the percentage designated in Exhibit A.

2. **Evaluation of ASA and Abandonment Rate**

(a) **The** ASA will be determined by measuring the sum of the total elapsed time between the moment when telephone callers to Service Centers select to speak with a customer

service representative and the time the callers are connected with a customer service representative, and dividing that number by the total number of telephone calls answered by the Service Center(s) during the Term.

(b) Abandonment Rate will be measured by dividing the total number of calls received within the Service Center(s) during the term that result in the caller terminating the call before speaking to a customer service representative by the total number of telephone calls received by the Service Center(s) during the Term, and expressing that number as a percent.

(c) The calculation of ASA and Abandonment Rate will be based on all calls received by the Service Center for all accounts in connection with those products that are provided by CIGNA to the Company.

3. **Telephone Services Penalties**

(a) **Telephone Average Speed to Answer Penalty.** The penalty for CIGNA's failure to meet the Telephone Average Speed to Answer Performance Commitment shall be shall be the amount shown in Exhibit A.

(b) **Telephone Abandonment Penalty.** The penalty for CIGNA's failure to meet the **Telephone** Abandonment Performance Commitment shall be shall be the amount shown in Exhibit A.

E. Account Management

1. **Account Management Commitment**. CIGNA's Account Management Sales Team commits to provide services to the Company of such quality as will result in CIGNA's achieving the Account Management Composite Score designated in Exhibit A on the Account Management Report Card. The Account Management Report Card is attached as Exhibit B to this Agreement and must be completed, signed and dated by the Company and returned to CIGNA on a quarterly basis.

2. **Evaluation of Account Management**

(a) At the beginning of the Term, the Company shall designate individuals on its benefits staff who will receive and complete the Account Management Report Card on a quarterly basis.

(b) The Account Management Report Card will be distributed to the Company's designated staff members on a quarterly basis and shall be completed, signed and dated by the Company and returned to CIGNA within three weeks of its distribution date. The failure of the Company to satisfy this condition shall nullify the Account Management Commitment.

(c) Following the end of the Term and receipt of the 4th quarterly survey from the Company, CIGNA will calculate the Composite Score in each performance assessment category by averaging the scores for the four quarters of the Term. The assessments of each of the designated staff members and each of the performance assessment categories will be weighted equally. The Account Management Commitment will be deemed as fulfilled if the average of the Composite Scores in each category (the "Account Management Composite Score") is equal to or greater than the Account Management Composite Score indicated on Exhibit A.

(d) CIGNA reserves the right to make changes in the staff/personnel assigned to an account during the Term.

3. **Account Management Penalty**. The penalty for CIGNA's failure to meet the Account Management Commitment shall be the amount shown in Exhibit A.

Section 4. Weighting of Performance Results

A. **Weighting of Results for Financial Accuracy and Claim Processing Accuracy**. Results for Financial Accuracy and Claim Processing Accuracy will be weighted to accurately reflect the proportion of Claims processed in each Claim Office on behalf of the Plan. Specifically, the results for each Claim Office during the Term will be multiplied by a fraction where the numerator is equal to the number of Claims processed in each Claim Office on behalf of the Plan and the denominator is equal to the total claims processed in all Claim Offices for the Plan. The resulting product for each Claim Office will be added together, and the sum will represent the "Weighted Result." The Weighted Result will determine whether the performance commitment has been met.

B. **Weighting of Results for Telephone Services**. Results for Telephone Services from each assigned Service Center will be weighted by call volume in order to calculate the overall result unless membership by site is made available.

Section 5. Evaluation of Services and Payment of Penalties

A. Within four months after the end of the Term, CIGNA shall compile the necessary documentation and perform the necessary calculations to evaluate its fulfillment of each performance commitment set forth in this Agreement and make this information available to the Company.

B. Any dispute with the amount CIGNA determines to be owed under this Agreement must be raised in writing within sixty (60) days of the date that CIGNA notifies the Company in writing of its determination.

C. If CIGNA fails to meet any of the performance commitments set forth in Section 3, CIGNA shall pay to the Company the appropriate financial penalty set forth in Exhibit A.

D. If the contract under which CIGNA provides insurance and/or administrative services to the Plan is terminated prior to the end of the Term of this Performance Guarantee Agreement, CIGNA shall have no liability under this Agreement.

E. In the event that this Agreement was not executed prior to the Effective Date and the duration of this contract is less than 12 consecutive months, the penalty amounts set forth in Exhibit A shall be pro-rated for that portion of the year for which performance measurements are in force, as described in Section 1.

F. The total amount payable by CIGNA during the Term for failure to meet the performance commitments set forth in this Agreement shall not exceed the sum of the penalties associated with each performance commitment, that amount being $34,334.

Section 6. Change in Reporting Format or Measurement

CIGNA reserves the right to replace or modify any performance commitment if necessitated by a change in circumstances that would cause the performance commitment to be an inaccurate or unfair method of measuring CIGNA's performance. In such event, the performance commitment will be modified to the degree necessary to carry out the intent of the parties. CIGNA shall provide no less than thirty (30) days' advance written notice of such modification(s).

Section 7. Setoff

CIGNA shall be entitled to setoff any amount owed by CIGNA to the Company under this Agreement against any debt owed by the Company to CIGNA, whether now existing or hereafter arising.

Section 8. Modification of Agreement

This Agreement constitutes the entire contract between the parties relating to the subject matter herein, and no modification or amendment hereto shall be valid unless in writing and signed by an officer of the Company and/or CIGNA's Regional Financial Officer.

Section 9. Termination of Agreement

This Agreement shall terminate upon the earliest of the following dates:

A. the end of the Term;

B. the effective date of any state's or other jurisdiction's action which prohibits activities of the parties under this Agreement;

C. the date upon which the Company either fails to meet its obligation to sufficiently fund the bank account from which claims are paid (if applicable), or fails to pay any premium charges, fees or other charges within the time frame specified in the applicable contract;

D. the date upon which the contract under which CIGNA provides services to the Company is terminated;

E. the date upon which any condition precedent set forth in Section 2 is not fulfilled, or

F. any other date mutually agreeable to the Company and CIGNA.

Section 10. Laws Governing Contract

This Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut.

Section 11. Resolution of Disputes - Arbitration

It is understood and agreed that any dispute, controversy or question arising under this Agreement shall be referred for decision by arbitration in Hartford, Connecticut by an arbitrator selected by the parties. The proceeding shall be governed by the Rules of the American Arbitration Association then in effect or such rules last in effect (in the event such Association is no longer in existence). If the parties are unable to agree upon such an arbitrator within thirty (30) calendar days after either party has given the other party written notice of its desire to submit the dispute, controversy or question for decision, then either party may apply to the American Arbitration Association for the appointment of an arbitrator or, if such Association is not then in existence or does not desire to act in the matter, each party shall appoint an arbitrator of its choice. The appointed arbitrators will select a third arbitrator to hear the parties and settle the dispute, controversy or question. The compensation and expenses of the arbitrator(s) and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by the parties.

Arbitration shall be the exclusive remedy for the settlement of disputes arising under this Agreement. The decision of the arbitrator(s) shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator(s).

This provision shall survive the termination of this Agreement.

Section 12. Third Party Beneficiaries

This Agreement is for the benefit of the Company and CIGNA and not for any other person. It shall not create any legal relationship between CIGNA and any employee, beneficiary or any other party claiming any right, whether legal or equitable, under the terms of this Agreement or the Plan.

Section 13. Waivers

No course of dealing or failure of either party to strictly enforce any term, right or condition of this Agreement shall be construed as a general waiver or relinquishment of such term, right or condition. Waiver by either party of any default shall not be deemed a waiver of any other default.

Section 14. Force Majeure

CIGNA shall not be liable for any failure to meet any of the obligations specified or required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of CIGNA, its employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or reasonably controlled by CIGNA, its employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations, whether valid or invalid.

Section 15. Headings

Section or paragraph headings contained in this Agreement are for reference purposes only and shall not affect the meaning or interpretation of this Agreement.

Section 16. Survival

Provisions contained in this Agreement that by their sense and context are intended to survive completion of performance, termination or cancellation of this Agreement shall so survive.

Section 17. Notices

Except as otherwise provided in this Agreement, all notices or other communications hereunder shall be deemed to have been duly given when made in writing and either a) delivered in person, b) delivered to an agent, such as an overnight or similar delivery service, or c) deposited in the United States mail, postage prepaid, and addressed as follows:

To CIGNA:
11001 N. Black Canyon Hwy, 4th floor
Phoenix, AZ 85029
Attention: Tim Thomas (Client Manager)

To the Company:
Maricopa County
320 W. Lincoln Street
Phoenix, AZ 85003
Attention: Materials Management

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in duplicate and signed by their respective officers duly authorized to do so as of the first date written above.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

By:_____

Title: __General Manager__

Date:_____ (required)

Maricopa County

By: _____

Title: _____

Date: _____ (required)

EXHIBIT A
PERFORMANCE COMMITMENTS AND PENALTIES – MEDICAL/DENTAL BENEFITS PLAN

Performance Category	**Performance Commitment**	**Results Measured At**	**Penalty Amount**
Claims Time-to-Process	Measured for the term of the Agreement, results will meet or exceed:		
-for Proclaim-resident accounts	• 90% Clean Claims processed w/in 14 Calendar Days	Account Level	**$15,000**
-for MHS/MHC resident accounts (for POS business only)	• 90% of Clean Claims processed w/in 14 Calendar days	Account Level	
Claims Accuracy	Measured for the term of the Agreement , results will meet or exceed:		
-Financial	• 99% of total audited claim dollars are correctly paid	Office Level	
-Processing	• 90% of total audited claims are correctly processed	Office Level	
Telephone Services	Measured for the term of the Agreement , results will not exceed:		
-Average Speed of Answer (ASA)	• 45 seconds to answer a phone call	Office Level	**$3,667**
-Call Abandonment Rate	• 5% of calls received by Call Center(s) terminated	Office Level	
Account Management	Account Management Composite Score (all categories) of 3.0 or better on the Account Management Report Card based on four (4) quarterly assessments.	N/A	**$15,667**
		Total Financial Commitment	**$34,334**

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

Client Name: Maricopa County_____
Account and/or SOC Number: _2459510_____
Agreement Term: From 01/01/2003 to 01/01/2003
Projected # of Enrolled Employee Lives: _1500__

Lead Claim Office: __Phoenix_____
Sales Office/Routing #: _Phoenix, 397_____
Sales Representative: _Tim Thomas_____
Underwriter Approval By: __Susan Pak_____

EXHIBIT B

ACCOUNT MANAGEMENT REPORT CARD

Rating Methodology:
5 = Completely Satisfied
4 = Very Satisfied
3 = Satisfied
2 = Somewhat Satisfied
1 = Dissatisfied

Client/Company Name: _Maricopa County_____
Completed By (please print): _____
Client Signature_____
Date completed: _____
Telephone #: _____

At the end of each quarterly period, please complete the box with the score that most closely reflects your level of satisfaction with the local account management team with respect to the following service categories. A separate quarterly report card must be completed, signed and dated each quarter.

Measurable Need	**1st Q**	**2nd Q**	**3rd Q**	**4th Q**	**Composite to be completed by PG Unit**
Delivers agreed upon reports and communication of CIGNA results on time. Delivery of Quarterly Utilization Reports Claim Processing Statistics (Semi-Annually)					

Fill in for each quarterly period:

Date Sent to Client:	__/ /__	__/ /__	__/ /__	__/ /__
Date Returned by Client:	__/ /__	__/ /__	__/ /__	__/ /__

If you rated any of the above categories less than "Satisfied" (3), please tell us why:

X 1st Q:

X 2nd Q:

X 3rd Q:

End of Year Comments:

Please return this form to: _____

EXHIBIT B-5
IMPLEMENTATION PERFORMANCE GUARANTEE AGREEMENT

THIS AGREEMENT is between Connecticut General Life Insurance Company, a CIGNA Company ("CIGNA"), and Maricopa County.

In connection with the services CIGNA will provide to the Company with respect to the employee welfare benefit plan sponsored by the Company (the "Plan"), CIGNA and the Company desire to implement performance guarantees according to the terms set forth below, effective as of the date this Agreement is executed by both parties (the "Performance Guarantee Effective Date"). Performance guarantees will be offered for the following products:

(Check which products the guarantee applies to)
Medical:
[X] Indemnity/PPO/PPA

Section 1. Term

The term of this Agreement (the "Term") shall be from the Performance Guarantee Effective Date through the last day of the twelfth (12th) consecutive month following the date on which coverage under the Plan administered by CIGNA becomes effective.

Section 2. Conditions Precedent

The Company acknowledges and agrees that conditions precedent to the effectiveness of this Agreement are as follows:

A. This Agreement is signed by both parties no later than thirty (30) days prior to the date on which coverage under the Plan administered by CIGNA becomes effective (the "Plan Effective Date"); if customized member collateral and/or ID cards have been requested, then the Agreement must be executed no later than sixty (60) days prior to the Plan Effective Date.

B. The benefits offered under the Plan, including both design and structure (the "Benefit Profile"), have been finalized and approved by the Company and CIGNA no later than thirty (30) days prior to the Plan Effective Date.

C. An implementation calendar, attached to this Agreement as Exhibit A and incorporated by this reference (the "Implementation Calendar"), has been finalized and approved by the Company and CIGNA.

D. The Company has fulfilled its obligations, as set forth in the Implementation Calendar. In the event that the Company determines it cannot fulfill an obligation as of a designated completion date, the Company shall notify CIGNA and the parties shall, if necessary, amend the Implementation Calendar, in writing, upon terms mutually agreeable to the parties.

E. The number of enrolled employees in that portion of the Plan administered by CIGNA exceeds 499 on the Plan Effective Date.

F. Where the Company or a third party is responsible for providing eligibility information or data of any kind to CIGNA, including but not limited to electronic data, tapes or software, the data is accurate and accessible.

Section 3. Performance Commitments and Penalty Amounts

In connection with the services CIGNA will provide to the Company with respect to the Plan, CIGNA guarantees its performance as stated below. (A summary of all performance commitments and their associated penalties is attached as Exhibit B.)

A. **Claim Readiness Performance Commitment.** The Benefit Profile and all complete and accurate eligibility information for each eligible participant under the Plan shall be loaded on CIGNA s claims processing system as of the Plan Effective Date.

The penalty for CIGNA's failure to meet the Claim Readiness Performance Commitment shall be the amount set forth in Exhibit B.

B. **Call Readiness Performance Commitment.** The Plan specifications shall be loaded into the applicable inquiry system with the Service Center(s) ready to respond to customer inquiries as of the Plan Effective Date.

The penalty for CIGNA's failure to meet the Claim Readiness Performance Commitment shall be the amount set forth in Exhibit B.

C. **Identification Card Delivery Performance Commitment.** A pre-determined percentage (%) of identification cards, as set forth in Exhibit B, for all eligible participants under the Plan for whom complete and accurate eligibility information has been received shall be mailed no later than the date set forth in Exhibit B.

The penalty for CIGNA's failure to meet the Identification Card Delivery Performance Commitment shall be the amount set forth in Exhibit B.

D. **Overall Satisfaction with Implementation Services Performance Commitment.** The Company shall be satisfied with the implementation process, as reflected by a score of no less than 3" on Question B.1. of the Implementation Service Evaluation, attached as Exhibit C to this Agreement. The Implementation Service Evaluation shall be provided to the Company within thirty (30) calendar days of the Plan Effective Date. The Implementation Service Evaluation shall be distributed to the Company s benefits staff, and the result shall be the average of every staff member s evaluation.

The penalty for CIGNA s failure to meet the Overall Satisfaction with Implementation Services Performance Commitment shall be the amount set forth in Exhibit B.

Section 4. Evaluation of Services and Payment of Penalties

A. Within four (4) months of the end of the Term, CIGNA shall compile the necessary documentation and perform the necessary calculations to evaluate its fulfillment of each performance commitment set forth in this Agreement and make this information available to the Company.

B. Any dispute with the amount CIGNA determines to be owed under this Agreement must be raised in writing within sixty (60) days of the date CIGNA notifies the Company of its determination.

C. If CIGNA fails to meet any of the performance commitments set forth in Section 3, CIGNA shall pay to the Company the appropriate financial penalty set forth in Exhibit B.

D. The total amount payable by CIGNA during the Term for failure to meet the performance commitments set forth in this Agreement shall not exceed the sum of the penalties associated with each performance commitment, that amount being $13,667

Section 5. Change in Reporting Format or Measurement

CIGNA reserves the right to replace or modify any performance commitment if necessitated by a change in circumstances that would cause the performance commitment to be an inaccurate or unfair method of measuring CIGNA's performance. In such event, the performance commitment will be modified to the degree necessary to carry out the intent of the parties.

Section 6. Setoff

CIGNA shall be entitled to setoff any amount owed by CIGNA to the Company under this Agreement against any debt owed by the Company to CIGNA, whether now existing or hereafter arising.

Section 7. Modification of Agreement

This Agreement constitutes the entire contract between the parties relating to the subject matter herein, and no modification or amendment hereto shall be valid unless in writing and signed by an officer of the Company and/or CIGNA's Regional Financial Officer.

Section 8. Termination of Agreement

This Agreement shall terminate upon the earliest of the following dates:

A. the end of the Term;

B. the effective date of any state's or other jurisdiction's action which prohibits activities of the parties under this Agreement;

C. the date upon which the Company either fails to meet its obligation to sufficiently fund the bank account from which claims are paid (if applicable), or fails to pay any premium charges, fees or other charges within the time frame specified in the applicable contract;

D. the date upon which the contract under which CIGNA provides services to the Company is terminated;

E. the date upon which any condition precedent set forth in Section 2 is not fulfilled; or

F. any other date mutually agreeable to the Company and CIGNA.

In the event that this Agreement is terminated for any of the reasons stated above, CIGNA shall have no obligation to pay any penalties under this Agreement.

Section 9. Laws Governing Contract

This Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut.

Section 10. Resolution of Disputes - Arbitration

It is understood and agreed that any dispute, controversy or question arising under this Agreement shall be referred for decision by arbitration in Hartford, Connecticut by an arbitrator selected by the parties. The proceeding shall be governed by the Rules of the American Arbitration Association then in effect or such rules last in effect (in the event such Association is no longer in existence). If the parties are unable to agree upon such an arbitrator within thirty (30) calendar days after either party has given the other party written notice of its desire to submit the dispute, controversy or question for decision, then either party may apply to the American Arbitration Association for the appointment of an arbitrator or, if such Association is not then in existence or does not desire to act in the matter, each party shall appoint an arbitrator of its choice. The appointed arbitrators will select a third arbitrator to hear the parties and settle the dispute, controversy or question. The compensation and expenses of the arbitrator(s) and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by the parties.

Arbitration shall be the exclusive remedy for the settlement of disputes arising under this Agreement. The decision of the arbitrator(s) shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator(s).

This provision shall survive the termination of this Agreement.

Section 11. Third Party Beneficiaries

This Agreement is for the benefit of the Company and CIGNA and not for any other person. It shall not create any legal relationship between CIGNA and any employee, beneficiary or any

other party claiming any right, whether legal or equitable, under the terms of this Agreement or the Plan.

Section 12. Waivers

No course of dealing or failure of either party to strictly enforce any term, right or condition of this Agreement shall be construed as a general waiver or relinquishment of such term, right or condition. Waiver by either party of any default shall not be deemed a waiver of any other default.

Section 13. Force Majeure

CIGNA shall not be liable for any failure to meet any of the obligations specified or required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of CIGNA, its employees, officers, or directors. Such contingencies include, but are not limited to, acts or

omissions of any person or entity not employed or reasonably controlled by CIGNA, its employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations, whether valid or invalid.

Section 14. Headings

Section or paragraph headings contained in this Agreement are for reference purposes only and shall not affect the meaning or interpretation of this Agreement.

Section 15. Survival

Provisions contained in this Agreement that by their sense and context are intended to survive completion of performance, termination or cancellation of this Agreement shall so survive.

Section 16. Notices

Except as otherwise provided in this Agreement, all notices or other communications hereunder shall be deemed to have been duly given when made in writing and either a) delivered in person, b) delivered to an agent, such as an overnight or similar delivery service, or c) deposited in the United States mail, postage prepaid, and addressed as follows:

To CIGNA:
11001 N. Black Canyon Hwy, 4th floor
Phoenix, AZ 85029
Attention: Tim Thomas (Client Manager)

To the Company:
Maricopa County
320 W. Lincoln Street
Phoenix, AZ 85003
Attention: Materials Management

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in duplicate and signed by their respective officers duly authorized to do so as of the first date written above.

CONNECTICUT GENERAL LIFE
INSURANCE COMPANY

By:_____
Title: General Manager

Date:_____ (required)

Maricopa County

By:_____
Title:

Date:_____ (required)

EXHIBIT A

IMPLEMENTATION CALENDAR

Task	Responsible	Start Date	Target Completion Date	Actual Completion Date
Introduce Implementation Team to Maricopa County; discuss benefits, reporting, structure, billing, eligibility, pre- and post-enrollment materials, claim forms, ID cards and claim requirements	CIGNA, Maricopa County	9/11/02	9/11/02	9/11/02
Confirm Maricopa County's approval of structure, benefit summary, sample bill, eligibility and overall implementation strategy as outlined in the Implementation Guide	CIGNA	9/12/02	9/25/02	
Meet with Eligibility Services to review automated eligibility tape requirements	Maricopa County, CIGNA	9/23/02	10/4/02	
Provide structure codes to Maricopa County for coding of enrollment forms	CIGNA	9/26/02	10/1/02	
Internal CIGNA Expert Team meeting to review account requirements	CIGNA	9/27/02	10/4/02	
Load account structure & benefits into CIGNA systems	CIGNA	10/4/02	11/1/02	
ID cards and claim forms ordered	CIGNA	9/26/02	10/4/02	
Open enrollment period for Maricopa County	Maricopa County, CIGNA	10/12/02	11/3/02	

Submit automated eligibility test tape	Maricopa County	11/5/02	11/5/02	
Process automated test tape and report results to client	CIGNA	11/6/02	11/12/02	
Submit automated eligibility production tape *	Maricopa County	12/5/02	12/5/02	
Collect and distribute enrollment forms to appropriate areas for manual eligibility loading* **(changes for COBRA & Retirees)**	Maricopa County, CIGNA	11/4/02	12/5/02	
Eligibility loaded into CED	CIGNA	12/6/02	12/18/02	
Release ID card production feed	CIGNA	12/18/02	12/18/02	
ID cards and post-enrollment collateral materials mailed	CIGNA	12/19/02	12/24/02	
Mail first bill	CIGNA	12/30/02	12/31/02	
Conduct wrap-up meeting regarding implementation	CIGNA, Maricopa County	1/30/03	1/31/03	

*Performance guarantee commitment and penalty amounts are subject to receipt of usable and complete eligibility information by the date listed.

The dates included in this Implementation Calendar are subject to change. If a change is necessary, CIGNA will work with you to reach a new agreement that reflects the changes in circumstances.

The term "CIGNA" refers to the various entities, which will provide the coverage and/or services described, including, but not limited to, Connecticut General Life Insurance Company, CIGNA HealthCare, CIGNA Dental Health, Intracorp, and CIGNA Behavioral Health.

EXHIBIT B

IMPLEMENTATION PERFORMANCE COMMITMENTS AND PENALTIES

Performance Category	**Performance Commitment**	**Penalty Amount**
Identification Card Delivery Performance Standard	98 % of Identification Cards mailed no later than 12/24/2002	**$10,000**
Call Readiness Performance Commitment	Service Center(s) ready to respond to customer inquiries as of Plan effective date.	**$3,667**
	Total Financial Commitment	**$ 13,667**

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

Client Name: Maricopa County_____

Lead Claim Office: _Phoenix_____

Account and/or SOC Number: _2459510_____

Sales Office/Routing #: __Phoenix/397_____

Contract Term: From 01/01 /2003 to 12/31/2003

Sales Representative: __Tim Thomas_____

Projected # of Enrolled Employee Lives: _1500___

Underwriter Approval By: _Susan Pak_

EXHIBIT B-6

PERFORMANCE INCENTIVE PROGRAM:

The County desires to implement a performance incentive plan for the general medical contractor to show its commitment to quality medical care. A payment of $40 per average annual active employee participation in each plan will be made after the contractor has documented achieving nine (9) of the twelve (12) POS/PPO criteria and nine (9) of the eleven (11) HMO/EPO criteria (the out-of-network POS claims administration criteria will not be included for the HMO). This incentive payment is in addition to your quoted rates.

1. Fully compliant HEDIS 2001 (or higher) reporting provided by July 1 of the following year. The HEDIS criteria for the HMO/EPO and POS/PPO will be analyzed separately if not reported on a combined basis. The reports must be for your commercial business in Maricopa County specific to the network you are proposing. The HEDIS definitions will be used for criteria two (2) through ten (10).

2. Smoking advice rate of the lesser of I) 65% or ii) or 10%, 20% and 30% over the 2002 base year rate for years 1, 2 and 3-10 of the contract respectively.

3. Breast cancer screening rates (age 52-69) of 80%.

4. Children's access to PCPs (12-24 months) of 94%.

5. A composite score of 90% or higher that doctors' office staff "usually" or "always" are courteous and helpful.

6. A composite score of 60% or higher of employees who rank their experience with the health plan an 8, 9 or 10.

7. Cervical cancer screening rates (age 21-64) of 85%.

8. Comprehensive diabetic care rate of 55%.

9. Adult access to preventive/ambulatory health services (age 20-44) of 90%.

10. Adult access to preventative/ambulatory health services (age 45-64) of 94%.

11. NCQA three-year accreditation status during the entire year.

12. POS out-of-network claims processing rates of 95% for procedural accuracy, 95% for payment accuracy, 99% for financial accuracy, and 90% of clean claims turned around in 14 calendar days.

CIGNA Healthcare - Stand Alone Medical Quote Only

EXHIBIT A

#REF!

1.0 PRICING:

1.1 General Medical

1.1.1 Fully Insured

	2004 Monthly Rate		
	Plan A: HMO	Plan B: POS	Plan C: PPO
Employee Only	$261.34	$272.96	$332.62
Employee + Children	$522.74	$546.05	$665.31
Employee + Spouse	$429.59	$448.84	$547.23
Employee + Family	$692.46	$723.38	$881.39
Post-65 Retiree	$452.79	$530.16	$558.37
Post-65 Retiree + Family	$1,018.78	$1,192.85	$1,256.34
Pre-65 Retiree	$565.99	$662.69	$697.97
Pre-65 Retiree + Family	$1,109.34	$1,298.88	$1,368.02

CHMO/POS PERFORMANCE GUARANTEE AGREEMENT **2004**

This Agreement is between Connecticut General Life Insurance Company, CIGNA HealthCare of Arizona, Inc., and Maricopa County (the "Company"). For purposes of this Agreement, Connecticut General Life Insurance Company and CIGNA HealthCare of Arizona, Inc., may be referred to collectively as "CIGNA".

In connection with the services CIGNA will provide to the Company with respect to the employee welfare benefit plan sponsored by the Company (the "Plan"), CIGNA and the Company desire to implement performance guarantees according to the terms set forth below, effective as of January 1, 2004 (the "Effective Date") and only for the Commercial HMO and POS medical coverage.

Section 1. Term

The term of this Agreement shall be from the Effective Date through the last day of the twelfth (12th) consecutive month following the Effective Date (the "Term").

Provided this Agreement is executed prior to the Effective Date, CIGNA's fulfillment of the performance commitments set forth in this Agreement shall be measured from the Effective Date.

In the event that it is not executed prior to the Effective Date, but the terms of this Agreement are exactly the same as the terms of the standard Performance Guarantee Agreement included in the Letter of Intent between CIGNA and Company attached here to as Exhibit C, if any, CIGNA's fulfillment of the performance commitments set forth herein shall be measured from the Effective Date.

In the event that it is not executed prior to the Effective Date, and the terms of this Agreement are not exactly the same as the standard Performance Guarantee Agreement included in the Letter of Intent between CIGNA and Company attached here to as Exhibit C, if any, CIGNA's performance shall be measured from the first day of the month following the month this Agreement is executed, or, if this Agreement is not executed before the sixteenth (16th) of the month, from the first day of the second month following the month this Agreement is executed. In such event, in accordance with Section 5, the applicable penalty amounts will be pro-rated for that portion of the year for which performance measurements are in force, and no penalty will be payable for any prior period notwithstanding anything to the contrary in a Letter of Intent.

Section 2. Conditions Precedent

The Company acknowledges and agrees that the conditions precedent to the effectiveness of this Agreement are as follows:

A The parties hereto must sign this Agreement no later than three (3) months following the Effective Date.

B The benefits offered under the Plan, including both design and structure (the "Benefit Profile"), have been finalized and approved by the Company and CIGNA prior to the Effective Date.

C The number of enrolled employees in the portion of the Plan administered by CIGNA will exceed 499.

D Where the Company or a third party is responsible for providing eligibility information or data of any kind to CIGNA, including but not limited to electronic data, tapes or software, the data is accurate and accessible.

Section 3. Ongoing Performance Commitments and Penalty Amounts

A. Time-to-Process (Applicable Only to Claims PMHS Claim Processing Systems)

1. **Time-to-Process Performance Commitments**

(a) **14 Day Time-to-Process Performance Commitment.** CIGNA shall process a designated percentage of Claims received in connection with the Plan during the Term within fourteen (14) calendar days. The designated percentage is shown in Exhibit A.

2. **Time-to-Process Results Measurement**

(a) The calculation of the time to process ("Time-to-Process") will based on Claims processed related to services provided by CIGNA to the Company Plan.

(b) Time-to-Process will be calculated by counting the number of calendar days from the calendar day that the Claim is received by CIGNA to and including the calendar day the Claim is processed. The calendar day that the claim is received will not be included in this calculation.

(c) A Claim is considered "processed" when a payment, explanation of benefits or written response is mailed to the claimant or the provider.

3. **Time-to-Process Penalties.**

(a) **14 Day Time-to-Process Penalty.** The penalty for CIGNA's failure to meet the 14 Day Time-to-Process Performance Commitment shall be the amount shown in Exhibit A.

B. **Financial Accuracy (Applicable Only to Claims PMHS Claim Processing Systems)**

1. **Financial Accuracy Performance Commitment.** The Service Center(s) servicing the Company (the "Service Center(s)") shall correctly pay a designated percentage of the total audited dollars paid in conjunction with routine claim audits conducted in the Service Center(s) during the Term ("Financial Accuracy"). The designated percentage is shown in Exhibit A.

2. **Evaluation of Financial Accuracy.** Fulfillment of the Financial Accuracy Performance Commitment set forth above will be determined as follows:

(a) Data used to determine Financial Accuracy will be comprised of claims audited in each Service Center in the course of routine claim audits during the Term.

(b) Financial Accuracy will be measured by subtracting the sum of the total dollars overpaid and the total dollars underpaid (without offsetting one against the other) in the audit population from the total audited dollars paid and dividing that amount by the total audited dollars paid.

3. **Financial Accuracy Penalty.** The penalty for CIGNA's failure to meet the Financial Accuracy Performance Commitment shall be the amount shown in Exhibit A.

C. **Claim Processing Accuracy (Applicable Only to Claims PMHS Claim Processing Systems)**

1. **Claim Processing Accuracy Performance Commitment.** The Service Center(s) servicing the Company (the "Service Center(s)") shall accurately process a designated percentage of the total audited claims processed in conjunction with routine claim audits conducted in the Service Center(s) during the Term ("Claim Processing Accuracy"). The designated percentage is shown in Exhibit A.

2. **Evaluation of Claim Processing Accuracy.** Fulfillment of the Claim Processing Accuracy Performance Commitment set forth above will be determined as follows:

(a) Data used to calculate Claim Processing Accuracy will be comprised of claim processing entries in conjunction with routine claim audits conducted in the Service Center(s), whether or not they have a financial impact on the claims processed, including but not limited to procedural and coding entries.

(b) Data used to determine Claim Processing Accuracy will be comprised of claims audited in each Service Center in the course of routine claim audits conducted during the Term.

(c) Claim Processing Accuracy will be measured by dividing the total number of claims in the audit population processed without any errors, by the total claims in the audit population, expressed as a percent.

3. **Claim Processing Accuracy Penalty.** The penalty for CIGNA's failure to meet the Claim Processing Performance Commitment shall be the amount shown in Exhibit A.

D. **Average Speed of Answer**

1 **Average Speed of Answer Commitment.** The average speed to answer a phone call to a Service Center(s) during the Term ("ASA") shall be no longer than the number of seconds designated in Exhibit A.

2 **Evaluation of Average Speed of Answer.**

(a) The ASA will be determined by measuring the sum of the total elapsed time between the moment when a telephone call is queued to the Service Center(s) and the time the caller is responded to, and dividing that number by the total number of telephone calls answered in the Service Center(s) during the Term.

(b) The calculation of ASA is based on all calls received by the Service Center(s) for all customers serviced in the Special Account Queue related to services provided by CIGNA to the Company Plan.

3 **Average Speed to Answer Penalty.** The penalty for CIGNA's failure to meet the Telephone Average Speed to Answer Performance Commitment shall be the amount shown in Exhibit A.

E. **Abandonment Rate**

1. **Telephone Abandonment Commitment**. The percentage of calls received by the Service Center(s) resulting in the caller terminating the call before speaking with a customer service representative (the "Abandonment Rate") shall, on average, be no greater than the percentage designated in Exhibit A.

2. **Evaluation of Abandonment Rate**

(a) Abandonment Rate will be calculated using the total number of calls received during the Term that result in the caller terminating after the call is queued to a customer service representative, divided by the total number of telephone calls received by the Service Center(s) during the Term, expressed as a percent.

(b) The calculation of Abandonment Rate is based on all calls received by the Service Center(s) for all customers serviced in the Special Account Queue related to services provided by CIGNA to the Company Plan.

3. **Abandonment Penalty.** The penalty for CIGNA's failure to meet the Telephone Abandonment Performance Commitment shall be the amount shown in Exhibit A.

F. **Account Management**

1. **Account Management Commitment**. CIGNA's Account Management Team commits to provide services to the Company of such quality as will result in CIGNA's achieving the Account Management Composite Score designated in Exhibit A on the Account Management Report Card. The Account Management Report Card is attached as Exhibit D to this Agreement and will be completed by the Company on a quarterly basis.

2. Evaluation of Account Management

(a) At the beginning of the Term, the Company shall designate individuals on its benefits staff who will receive and complete the Account Management Report Card on a quarterly basis.

(b) The Account Management Report Card will be distributed to the Company's designated staff members on a quarterly basis and shall be completed and returned to CIGNA by the Company within three weeks of its distribution date. The failure of the Company to satisfy this condition shall nullify the Account Management Commitment.

(c) Following the end of the Term and receipt of the 4th quarterly survey from the Company, CIGNA will calculate the Composite Score in each performance assessment category by averaging the scores for the four quarters of the Term. The assessments of each of the designated staff members and each of the performance assessment categories will be weighted equally. The Account Management Commitment will be deemed as fulfilled if the average of the Composite Scores in each category (the "Account Management Composite Score") is equal to or greater than the Account Management Composite Score indicated on Exhibit A.

(d) CIGNA reserves the right to make changes in the staff/personnel assigned to an account during the Term.

3. Account Management Penalty. The penalty for CIGNA's failure to meet the Account Management Commitment shall be the amount shown in Exhibit A.

Section 4. Weighting of Performance Results

A. **Weighting of Results for Financial Accuracy, Claim Processing Accuracy, and Claim Payment Accuracy**. Results for Financial Accuracy, Claim Processing Accuracy, and Claim Payment Accuracy will be weighted to accurately reflect the proportion of Claims processed in each Claim Office on behalf of the Company. Specifically, the results for each Claim Office for the Term will be multiplied by a fraction where the numerator is equal to the number of Claims processed in each Claim Office on behalf of the Company and the denominator is equal to the total claims processed in all Claim Offices for the Company. The resulting product for each Claim Office will be added together, and the sum will represent the "Weighted Result." The Weighted Result will determine whether the performance commitment has been met.

Sampling results of medical claim quality audits will be weighted, as appropriate, by groupings established according to a range of claim dollar amounts, used within the sample.

B. **Weighting of Results for Telephone Services**. When more than one Inquiry Center is assigned to handle member inquiries, results for Telephone Services from each assigned Inquiry Center will be weighted equally in order to calculate the overall result.

Section 5. Evaluation of Services and Payment of Penalties

A. Within four (4) months after the end of the Term, CIGNA shall compile the necessary documentation and perform the necessary calculations to evaluate its fulfillment of each performance commitment set forth in this Agreement and make this information available to the Company.

B. Any dispute with the amount CIGNA determines to be owed under this Agreement must be raised in writing within sixty (60) days of the date CIGNA notifies the Company in writing of its determination.

C. If CIGNA fails to meet any of the performance commitments set forth in Section 3, CIGNA shall pay to the Company the appropriate financial penalty set forth in Exhibit A.

D. If the contract under which CIGNA provides insurance and/or administrative services to the Plan is terminated prior to the end of the Term of this Performance Guarantee Agreement, CIGNA shall have no liability under this Agreement.

E. In the event that, in accordance with Section 1, the period during which performance is measured is less than 12 consecutive months, the penalty amounts set forth in Exhibit A shall be pro-rated for that portion of the year for which performance measurements are in force.

F. The total amount payable by CIGNA during the Term for failure to meet the performance commitments set forth in this Agreement shall not exceed the sum of the penalties associated with each performance commitment, that amount being $60,000

Section 6. Change in Reporting Format or Measurement

CIGNA reserves the right to replace or modify any performance commitment if necessitated by a change in circumstances that would cause the performance commitment to be an inaccurate or unfair method of measuring CIGNA's performance. In such event, the performance commitment will be modified to the degree necessary to carry out the intent of the parties.

Section 7. Setoff

CIGNA shall be entitled to setoff any amount owed by CIGNA to the Company under this Agreement against any debt owed by the Company to CIGNA, whether now existing or hereafter arising.

Section 8. Modification of Agreement

This Agreement constitutes the entire contract between the parties relating to the subject matter herein, and no modification or amendment hereto shall be valid unless in writing and signed by an officer of the Company and/or CIGNA's Regional Financial Officer.

Section 9. Termination of Agreement

A. This Agreement shall terminate upon the earliest of the following dates:

1. The end of the Term;
2. the effective date of any state's or other jurisdiction's action which prohibits activities of the parties under this Agreement;
3. the date upon which the Company either fails to meet its obligation to sufficiently fund the bank account from which claims are paid (if applicable), or fails to pay any premium charges, fees or other charges within the time frame specified in the applicable contract;
4. the date upon which the contract under which CIGNA provides services to the Company is terminated;
5. the date upon which any condition precedent set forth in Section 2 is not fulfilled; or
6. any other date mutually agreeable to the Company and CIGNA

Section 10. Laws Governing Contract

This Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut and the State of Arizona.

Section 11. Resolution of Disputes - Arbitration

It is understood and agreed that any dispute, controversy or question arising under this Agreement shall be referred for decision by arbitration in Hartford, Connecticut by an arbitrator selected by the parties. The proceeding shall be governed by the Rules of the American Arbitration Association then in effect or such rules last in effect (in the event

such Association is no longer in existence). If the parties are unable to agree upon such an arbitrator within thirty (30) calendar days after either party has given the other party written notice of its desire to submit the dispute, controversy or question for decision, then either party may apply to the American Arbitration Association for the appointment of an arbitrator or, if such Association is not then in existence or does not desire to act in the matter, each party shall appoint an arbitrator of its choice. The appointed arbitrators will select a third arbitrator to hear the parties and settle the dispute, controversy or question. The compensation and expenses of the arbitrator(s) and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by the parties.

Arbitration shall be the exclusive remedy for the settlement of disputes arising under this Agreement. The decision of the arbitrator(s) shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator(s).

This provision shall survive the termination of this Agreement.

Section 12. Third Party Beneficiaries

This Agreement is for the benefit of the Company and CIGNA and not for any other person. It shall not create any legal relationship between CIGNA and any employee, beneficiary or any other party claiming any right, whether legal or equitable, under the terms of this Agreement or the Plan.

Section 13. Waivers

No course of dealing or failure of either party to strictly enforce any term, right or condition of this Agreement shall be construed as a general waiver or relinquishment of such term, right or condition. Waiver by either party of any default shall not be deemed a waiver of any other default.

Section 14. Force Majeure

CIGNA shall not be liable for any failure to meet any of the obligations specified or required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of CIGNA, its employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or reasonably controlled by CIGNA, its employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations, whether valid or invalid.

Section 15. Headings

Section or paragraph headings contained in this Agreement are for reference purposes only and shall not affect the meaning or interpretation of this Agreement.

Section 16. Survival

Provisions contained in this Agreement that by their sense and context are intended to survive completion of performance, termination or cancellation of this Agreement shall so survive.

Section 17. Notices

Except as otherwise provided in this Agreement, all notices or other communications hereunder shall be deemed to have been duly given when made in writing and either a) delivered in person, b) delivered to an agent, such as an overnight or similar delivery service, or c) deposited in the United States mail, postage prepaid, and addressed as follows:

To CIGNA:
11001 N. Black Canyon Hwy, 4th floor
Phoenix, AZ 85029
Attention: Tim Thomas (Client Manager)

To the Company:

Maricopa County
320 W. Lincoln Street
Phoenix, AZ 85003
Attention: Materials Management

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in duplicate and signed by their respective officers duly authorized to do so as of the first date written above.

CIGNA HealthCare of Arizona, Inc.

By:_____

Title: __General Manager____

Date:_____ (required)

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

By:_____

Title: _____

Date:_____ (required)

Maricopa County

By: _____

Title: _____

Date: _____ (required)

EXHIBIT A

PERFORMANCE COMMITMENTS AND PENALTIES – CHMO/POS MEDICAL BENEFITS

Performance Category	**Performance Commitment**	**Penalty Amount**
Telephone Services **Average Speed of Answer ("ASA"), Special Account Queue Level** **Call Abandonment Rate, Special Account Queue Level**	Average Inquiry Site results will not exceed: ▪ 45 seconds to answer a phone call ▪ 5% of calls received by Call Center(s) terminated	 $10,000 $10,000
Claims Time to Process -For PHMS (Account Level) **Medical Claims Accuracy** -Financial (Office Level) -Processing (Office Level)	90% of claims processed w/in 14 calendar days 99% of total audited claim dollars are correctly paid 90% of total audited claim dollars are processed	$10,000 $10,000 $10,000
Account Management	Account Management Composite Score (all categories) of 3.0 or better on the Account Management Report Card based on four (4) quarterly assessments.	**$10,000**
	Total Financial Commitment	**$60,000**

CONNECTICUT GENERAL LIFE INSURANCE COMPANY and CHC of Arizona

Client Name: _Maricopa County_____ Lead Claim Office: _____

Account Number: _3205496_____ Sales Office/Routing #: __Phoenix/397___

Contract Term: From 01/01/2004 to12/31/2004 Sales Representative: __Tim Thomas____

Projected # of Enrolled Employee Lives: 8372___ Underwriter Approval By: _Susan Pak____

PERFORMANCE GUARANTEE AGREEMENT FOR CIGNA'S ANNUAL SERVICE METRICS 2004

This Agreement is between Connecticut General Life Insurance Company, a CIGNA Company ("CIGNA"), and _Maricopa County (the "Company").

In connection with the services CIGNA will provide to the Company with respect to the employee welfare benefit plan sponsored by the Company (the "Plan"), CIGNA and the Company desire to implement performance guarantees according to the terms set forth below, effective as of _January 1, 2004 (the "Effective Date") for the following products:

(Check which products the guarantee applies to)
Medical:
[X] Indemnity/PPO

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Section 1. Term

The term of this Agreement shall be from the Effective Date through the last day of the twelfth (12th) consecutive month following the Effective Date (the "Term").

Provided this Agreement is executed prior to the Effective Date, CIGNA's fulfillment of the performance commitments set forth in this Agreement shall be measured from the Effective Date.

In the event that it is not executed prior to the Effective Date, but the terms of this Agreement are exactly the same as the terms of the standard Performance Guarantee Agreement included in the Letter of Intent between CIGNA and Company attached hereto as Exhibit C, if any, CIGNA's fulfillment of the performance commitments set forth herein shall be measured from the Effective Date.

In the event that it is not executed prior to the Effective Date, and the terms of this Agreement are not exactly the same as the standard Performance Guarantee Agreement included in the Letter of Intent between CIGNA and Company attached hereto as Exhibit C, if any, CIGNA's performance shall be measured from the first day of the month following the month this Agreement is executed, or, if this Agreement is not executed before the sixteenth (16th) of the month, from the first day of the second month following the month this Agreement is executed. In such event, in accordance with Section 5, the applicable penalty amounts will be pro-rated for that portion of the year for which performance measurements are in force, and no penalty will be payable for any prior period notwithstanding anything to the contrary in a Letter of Intent.

Section 2. Conditions Precedent

The Company acknowledges and agrees that the conditions precedent to the effectiveness of this Agreement are as follows:

A. Both parties must sign this Agreement no later than three (3) months following the Effective Date.

B. The benefits offered under the Plan, including both design and structure (the "Benefit Profile"), have been finalized and approved by the Company and CIGNA prior to the Effective Date.

C. The number of enrolled employees in that portion of the Plan that is administered by CIGNA exceeds 499 on the Effective Date.

D. Where the Company or a third party is responsible for providing eligibility information or data of any kind to CIGNA, including but not limited to electronic data, tapes or software, the data is accurate, accessible and received by CIGNA within the predetermined timelines.

Section 3. Performance Commitments and Penalty Amounts

In connection with the services CIGNA will provide to the Company with respect to the Plan, CIGNA guarantees its performance as stated below. (A summary of all performance commitments and their associated penalties is attached as Exhibit A).

A. Time-to-Process

1. **Time-to-Process Performance Commitments**

   (a) **14 Day Time-to-Process Performance Commitment.** CIGNA shall process a designated percentage of Claims received in connection with the Plan during the Term within fourteen (14) calendar days. The designated percentage is shown in Exhibit A.

2. **Time-to-Process Results Measurement**

   (a) The calculation of the time to process ("Time-to-Process") will based on Claims processed related to services provided by CIGNA to the Company Plan.

   (b) Time-to-Process will be calculated by counting the number of calendar days from the calendar day that the Claim is received by CIGNA to and including the calendar day the Claim is processed. The calendar day that the Claim is received will not be included in this calculation.

   (c) A Claim is considered "processed" when a payment, explanation of benefits or written response is mailed to the claimant or the provider.

3. **Time-to-Process Penalties.**

   (a) **14 Day Time-to-Process Penalty.** The penalty for CIGNA's failure to meet the 14 Day Time-to-Process Performance Commitment shall be the amount shown in Exhibit A.

B. **Financial Accuracy**

1. **Financial Accuracy Performance Commitment.** The Service Center(s) servicing the Company (the "Service Center(s)") shall correctly pay a designated percentage of the total audited dollars paid in conjunction with routine claim audits conducted in the Service Center(s) for the same product(s) that are provided by CIGNA to the Company during the Term ("Financial Accuracy"). The designated percentage is shown in Exhibit A.

2. **Evaluation of Financial Accuracy.** Fulfillment of the Financial Accuracy Performance Commitment set forth above will be determined as follows:

   (a) Data used to determine Financial Accuracy will be comprised of claims audited in each Service Center in the course of routine claim audits for the same product(s) that are provided by CIGNA to the Company during the Term.

   (b) Financial Accuracy will be measured by subtracting the sum of the total dollars overpaid and the total dollars underpaid (without offsetting one against the other) in the audit population from the total audited dollars paid and dividing that amount by the total audited dollars paid.

3. **Financial Accuracy Penalty.** The penalty for CIGNA's failure to meet the Financial Accuracy Performance Commitment shall be the amount shown in Exhibit A.

C. Claim Processing Accuracy

1. **Claim Processing Accuracy Performance Commitment.** The Service Center(s) servicing the Company (the "Service Center(s)") shall accurately process a designated percentage of the total audited claims processed in conjunction with routine claim audits conducted in the Service Center(s) for the same product(s) that are provided by CIGNA to the Company during the Term ("Claim Processing Accuracy"). The designated percentage is shown in Exhibit A.

2. **Evaluation of Claim Processing Accuracy.** Fulfillment of the Claim Processing Accuracy Performance Commitment set forth above will be determined as follows:

   (a) Data used to calculate Claim Processing Accuracy will be comprised of claim processing entries in conjunction with routine claim audits conducted in the Service Center(s), whether or not they have a financial impact on the claims processed, including but not limited to procedural and coding entries.

   (b) Data used to determine Claim Processing Accuracy will be comprised of claims audited in each Service Center in the course of routine claim audits for the same product(s) that are provided by CIGNA to the Company during the Term.

   (c) Claim Processing Accuracy will be measured by dividing the total number of claims in the audit population processed without any errors, by the total claims in the audit population, expressed as a percent.

3. **Claim Processing Accuracy Penalty.** The penalty for CIGNA's failure to meet the Claim Processing Performance Commitment shall be the amount shown in Exhibit A.

D. **Average Speed of Answer**

1. **Average Speed of Answer Commitment.** The average speed to answer a phone call to a Service Center(s) during the Term ("ASA") shall be no longer than the number of seconds designated in Exhibit A.

2. **Evaluation of Average Speed of Answer.**

   (a) The ASA will be determined by measuring the sum of the total elapsed time between the moment when a telephone call is queued to a Service Center(s) and the time the caller is responded to, and dividing that number by the total number of telephone calls answered in the Service Center(s) during the Term.

   (b) The calculation of ASA is based on all calls received by the Service Center(s) for all customers serviced in the Special Account Queue related to services provided by CIGNA to the Company Plan.

3. **Average Speed to Answer Penalty.** The penalty for CIGNA's failure to meet the Telephone Average Speed to Answer Performance Commitment shall be the amount shown in Exhibit A.

E. **Abandonment Rate**

1. **Telephone Abandonment Commitment**. The percentage of calls received by the Service Center resulting in the caller terminating the call before speaking with a customer service representative (the "Abandonment Rate") shall, on average, be no greater than the percentage designated in Exhibit A.

2. **Evaluation of Abandonment Rate**

   (a) Abandonment Rate will be calculated using the total number of calls received during the Term that result in the caller terminating after the call is queued to a customer service representative, divided by the total number of telephone calls received by the Service Center(s) during the Term, expressed as a percent.

   (b) The calculation of Abandonment Rate is based on all calls received by the Service Center(s) for all customers serviced in the Special Account Queue related to services provided by CIGNA to the Company Plan.

3. **Abandonment Penalty.** The penalty for CIGNA's failure to meet the Telephone Abandonment Performance Commitment shall be the amount shown in Exhibit A.

F. Account Management

1. **Account Management Commitment**. CIGNA's Account Management Sales Team commits to provide services to the Company of such quality as will result in CIGNA's achieving the Account Management Composite Score designated in Exhibit A on the Account Management Report Card. The Account Management Report Card is attached as Exhibit B to this Agreement and must be completed, signed and dated by the Company and returned to CIGNA on a quarterly basis.

2. **Evaluation of Account Management**

   (a) At the beginning of the Term, the Company shall designate individuals on its benefits staff who will receive and complete the Account Management Report Card on a quarterly basis.

   (b) The Account Management Report Card will be distributed to the Company's designated staff members on a quarterly basis and shall be completed, signed and dated by the Company and returned to CIGNA within three weeks of its distribution date. The failure of the Company to satisfy this condition shall nullify the Account Management Commitment.

   (c) Following the end of the Term and receipt of the 4th quarterly survey from the Company, CIGNA will calculate the Composite Score in each performance assessment category by averaging the scores for the four quarters of the Term. The assessments of each of the designated staff members and each of the performance assessment categories will be weighted equally. The Account Management Commitment will be deemed as fulfilled if the average of the Composite Scores in each category (the "Account Management Composite Score") is equal to or greater than the Account Management Composite Score indicated on Exhibit A.

   (d) CIGNA reserves the right to make changes in the staff/personnel assigned to an account during the Term.

3. **Account Management Penalty**. The penalty for CIGNA's failure to meet the Account Management Commitment shall be the amount shown in Exhibit A.

Section 4. Weighting of Performance Results

A. **Weighting of Results for Financial Accuracy, Claim Processing Accuracy, and Claim Payment Accuracy**. Results for Financial Accuracy, Claim Processing Accuracy, and Claim Payment Accuracy will be weighted to accurately reflect the proportion of Claims processed in each Claim Office on behalf of the Company. Specifically, the results for each Claim Office for the Term will be multiplied by a fraction where the numerator is equal to the number of Claims

processed in each Claim Office on behalf of the Company and the denominator is equal to the total claims processed in all Claim Offices for the Company. The resulting product for each Claim Office will be added together, and the sum will represent the "Weighted Result." The Weighted Result will determine whether the performance commitment has been met.

B. **Weighting of Results for Telephone Services**. Results for Telephone Services from each assigned Service Center will be weighted by call volume in order to calculate the overall result unless membership by site is made available.

Section 5. Evaluation of Services and Payment of Penalties

A. Within four months after the end of each Term, CIGNA shall compile the necessary documentation and perform the necessary calculations to evaluate its fulfillment of each performance commitment set forth in this Agreement and make this information available to the Company.

B. Any dispute concerning the amount CIGNA determines to be owed under this Agreement must be raised in writing within sixty (60) days of the date that CIGNA notifies the Company in writing of its determination.

C. If CIGNA fails to meet any of the performance commitments set forth in Section 3, CIGNA shall pay to the Company the appropriate financial penalty set forth in Exhibit A.

D. If the contract under which CIGNA provides insurance and/or administrative services to the Plan is terminated prior to the end of the Term of this Performance Guarantee Agreement, CIGNA shall have no liability under this Agreement.

E. In the event that, in accordance with Section 1, the period during which performance is measured is less than 12 consecutive months, the penalty amounts set forth in Exhibit A shall be pro-rated for that portion of the year for which performance measurements are in force.

F. The total amount payable by CIGNA during the Term for failure to meet the performance commitments set forth in this Agreement shall not exceed the sum of the penalties associated with each performance commitment, that amount being $_30,000__.

Section 6. Change in Reporting Format or Measurement

Notwithstanding anything to the contrary contained in Section 8, CIGNA reserves the right to replace or modify any performance commitment if necessitated by a change in the way CIGNA tracks or measures the applicable performance metric. In formulating any such substitute commitment, CIGNA shall, to the extent possible, attempt to reflect the same performance level reflected in the original commitment, consistent with its new measurement/tracking methodology. CIGNA shall explain the reasons for the change of any performance commitment pursuant to this Section 6 when it notifies the Company of the substitute commitment. CIGNA shall provide no less than thirty (30) days' advance notice of such modification.

Section 7. Setoff

CIGNA shall be entitled to setoff any amount owed by CIGNA to the Company under this Agreement against any debt owed by the Company to CIGNA, whether now existing or hereafter arising.

Section 8. Modification of Agreement

This Agreement constitutes the entire contract between the parties relating to the subject matter herein, and no modification or amendment hereto shall be valid unless in writing and signed by an officer of the Company and CIGNA's Regional Financial Officer.

Section 9. Termination of Agreement

This Agreement shall terminate upon the earliest of the following dates:

A. the end of the Term of this agreement;

B. the effective date of any state's or other jurisdiction's action which prohibits activities of the parties under this Agreement;

C. the date upon which the Company either fails to meet its obligation to sufficiently fund the bank account from which claims are paid (if applicable), or fails to pay any premium charges, fees or other charges within the time frame specified in the applicable contract;

D. the date upon which the contract under which CIGNA provides services to the Company is terminated;

E. the date upon which any condition precedent set forth in Section 2 is not fulfilled, or

F. any other date mutually agreeable to the Company and CIGNA.

Section 10. Laws Governing Contract

This Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut.

Section 11. Resolution of Disputes - Arbitration

It is understood and agreed that any dispute, controversy or question arising under this Agreement shall be referred for decision by arbitration in Hartford, Connecticut by an arbitrator selected by the parties. The proceeding shall be governed by the Rules of the American Arbitration Association then in effect or such rules last in effect (in the event such Association is no longer in existence). If the parties are unable to agree upon such an arbitrator within thirty (30) calendar days after either party has given the other party written notice of its desire to submit the dispute, controversy or question for decision, then either party may apply to the American Arbitration Association for the appointment of an arbitrator or, if such Association is not then in existence or does not desire to act in the matter, each party shall appoint an arbitrator of its choice. The appointed arbitrators will select a third arbitrator to hear the parties and settle the dispute, controversy or question. The compensation and expenses of the arbitrator(s) and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by the parties.

Arbitration shall be the exclusive remedy for the settlement of disputes arising under this Agreement. The decision of the arbitrator(s) shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator(s).

This provision shall survive the termination of this Agreement.

Section 12. Third Party Beneficiaries

This Agreement is for the benefit of the Company and CIGNA and not for any other person. It shall not create any legal relationship between CIGNA and any employee, beneficiary or any other party claiming any right, whether legal or equitable, under the terms of this Agreement or the Plan.

Section 13. Waivers

No course of dealing or failure of either party to strictly enforce any term, right or condition of this Agreement shall be construed as a general waiver or relinquishment of such term, right or condition. Waiver by either party of any default shall not be deemed a waiver of any other default.

Section 14. Force Majeure

CIGNA shall not be liable for any failure to meet any of the obligations specified or required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of CIGNA, its employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or reasonably controlled by CIGNA, its employees, officers, or directors, acts of God, fires, wars,

accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations, whether valid or invalid.

Section 15. Headings

Section or paragraph headings contained in this Agreement are for reference purposes only and shall not affect the meaning or interpretation of this Agreement.

Section 16. Survival

Provisions contained in this Agreement that by their sense and context are intended to survive completion of performance, termination or cancellation of this Agreement shall so survive.

Section 17. Notices

Except as otherwise provided in this Agreement, all notices or other communications hereunder shall be deemed to have been duly given when made in writing and either a) delivered in person, b) delivered to an agent, such as an overnight or similar delivery service, or c) deposited in the United States mail, postage prepaid, and addressed as follows:

To CIGNA:
_11001 N. Black Canyon Hwy, 4th Floor
_Phoenix, AZ 85029_____
_____
Attention:___Tim Thomas_____

To the Company:
__Maricopa County_____
__320 W. Lincoln Street_____
__Phoenix, AZ 85003_____
Attention:___Materials Managment____

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in duplicate and signed by their respective officers duly authorized to do so as of the first date written above.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

By:_____

Title: __General Manager_____

Date:_____ (required)

Maricopa County

By: _____

Title: _____

Date: _____ (required)

EXHIBIT A
PERFORMANCE COMMITMENTS AND PENALTIES – MEDICAL/DENTAL BENEFITS PLAN

Performance Category	**Performance Commitment**	**Results Measured At**	**Penalty Amount**
Claims Time-to-Process -For Proclaim (Medical) resident accounts	Measured for the term of the Agreement, results will meet or exceed: • 90% claims processed w/in 14 Calendar Days	Account Level	**$5,000**
Medical Claims Accuracy -Financial -Processing	Measured for the term of the Agreement, results will meet or exceed: • 99% of total audited claim dollars are correctly paid • 90% of total audited claims are correctly processed	Office Level Office Level	**$5,000**
Call/Inquiry -Average Speed of Answer (ASA) -Call Abandonment Rate	Measured for the term of the Agreement , results will not exceed: • 45 seconds to answer a phone call • 5% of calls received by Call Center(s) terminated	Office Level Office Level	**$5,000** **$5,000**
Account Management	Account Management Composite Score (all categories) of 3.0 or better on the Account Management Report Card based on four (4) quarterly assessments.	Account Level	**$5,000**
		Total Financial Commitment	**$30,000**

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

Client Name: _Maricopa County_____ Account and/or SOC Number: _2459510 /25786_ Lead Claim Office: ___Phoenix_____
Agreement Term: From 01/01/2004 to 12 /31/2004 Projected # of Enrolled Employee Lives: __250_____
Sales Representative: __Tim Thomas_____ Sales Office/Routing #: __Phoenix 397_____ Underwriter Approval By: _Susan Pak_____

EXHIBIT B

ACCOUNT MANAGEMENT REPORT CARD

Rating Methodology:
5 = Completely Satisfied
4 = Very Satisfied
3 = Satisfied
2 = Somewhat Satisfied
1 = Dissatisfied

Client/Company Name: _____
Completed By (please print): _____
Client Signature_____
Date completed: _____
Telephone #: _____

At the end of each quarterly period, please complete the box with the score that most closely reflects your level of satisfaction with the local account management team with respect to the following service categories. A separate quarterly report card must be completed, signed and dated each quarter.

Measurable Need	**1st Q**	**2nd Q**	**3rd Q**	**4th Q**	**Composite to be completed by PG Unit**
Deliver agreed upon reports and communication of CIGNA results on time. -Delivery of Quarterly Utilization Reports -Claim Processing Statistics (Semi-Annually)					
Account Management Composite Score (All Categories)	N/A	N/A	N/A	N/A	

Fill in for each quarterly period:
Date Sent to Client: __/ /__ __/ /__ __/ /__ __/ /__
Date Returned by Client: __/ /__ __/ /__ __/ /__ __/ /__

If you rated any of the above categories less than "Satisfied" (3), please tell us why:

X 1st Q:

X 2nd Q:

X 3rd Q:

End of Year Comments:

Please return this form to: _____

EXHIBIT B-2

2004	A. HMO	B. POS		C. PPO	
	In-Network	In-Network	Out-of Network	In-Network	Out-of Network
Standard Benefit Coverage					
Deductible					
Individual	None	None	$300	$250	$750
Family	None	None	$600	$500	$1,500
Standard Coinsurance Percentage	100%	100%	70%	80%	60%
Coinsurance on Next $ x,xxx Covered Expenses (then 100%)					
Individual	$1,000 OOP Max	$900 OOP Max	$3,000 OOP Max	$2,000 OOP Max	$4,000 OOP Max
Family	$2,000 OOP Max	$1,800 OOP Max	$6,000 OOP Max	$6,000 OOP Max	$12,000 OOP Max
Lifetime Maximum Benefit	Unlimited	Unlimited	$5,000,000	Unlimited	$5,000,000
Pre-existing Conditions	None	None	12 Months Coverage, waived if covered 1/01/03	12 Months Coverage, waived if covered 1/01/03	12 Months Coverage, waived if covered 1/01/03
General Services					
Preventive Care	$10 Copay	$15 Copay	Covered In-Network Only	80%	Covered In-Network Only
Primary Care Physician Services	$10 Copay	$15 Copay	70%	80%	60%
Specialty Care Physician Services	$10 Copay	$25 Copay	70%	80%	60%
Urgent Care (Participating)	$35 Copay	$50 Copay	70%	$50 Copay	70%
Outpatient Lab and X-Ray	$0 lab or X-Ray $50 for MRI & CAT	$0 lab or X-Ray $50 for MRI & CAT	70%	80% Coinsurance	60%
Inpatient Coverage					
Facility Charges	No Copay	$100 Copay/Day, $300 Maximum per Admission	70% (Precertification Required)*	80%	60% (Precertification Required)*
Physician & Surgeon's Services	No Copay	No Copay	70% (Precertification Required)*	80%	60% (Precertification Required)*

Outpatient Surgery	No Copay	$100 Copay	70% (Precertification Required)*	80%	60% (Precertification Required)*
Precertification Penalty*	NA	NA	$400	$400	$400
Maternity					
Pre & Postnatal Exams(after pregnancy has been determined)	Copay waived after 1st visit	Copay waived after 1st visit	70%	Copay waived after 1st visit	60%
Delivery	Copay waived	$100 Copay/Day, $300 Maximum per Admission	70%	80%	60%
Emergency Care (Defined by Plan)					
Emergency Room	$75 Copay	$100 Copay	$100 Copay if emergency, otherwise 70%	$100 Copay	$100 Copay if emergency, otherwise 60%
Ambulance	No Copay	No Copay	No Copay	90%	90%
Equipment and Devices					
Durable Medical Equipment	No Copay (CIGNA requires $3500 Max)	No Copay (CIGNA requires $3500 Max)	Covered In-Network Only	80% ($700 max.)	60% ($700 max.)
External Prosthetics, Orthotics and Colostomy Bags	*No Copay ($1000 Max)*	*No Copay ($1000 Max)*	Covered In-Network Only	80% ($200 ded., $1,000 max.)	60% ($200 ded., $1000 max.)
Outpatient Rehabilitation					
Physical, Speech, and Occupational Therapy	*$10 Copay*	*$15 Copay*	70%	80%*	60%*
Chiropractic Services	*$10 Copay*	*$15 Copay*	70%, Chiropractic Covered In-Network Only	80%**	60%**
Open access - no referral from PCP	*20 visits*	*20 visits*	Covered In-Network Only	Unilimited Visits**	Unlimited Visits**
Limit	60 Visits	60 visits combined		*60 visits combined	

				** Unlimited Visits	
Ancillary Benefits					
Vision	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Exam	$10 Copay	$15 Copay	Not Covered	$20 Copay	Not Covered
Other Healthcare Facilities					
Skilled Nursing Facilities					
Subscriber Payment	No Copay	No Copay	70%	80%	60%
Limit per Contract Year	*90 Days Combined*	*90 Days Combined*	*90 Days Combined*	90 Days Combined	90 Days Combined
Home Health Care	No Copay when medically necessary (Unlimited)	No Copay when medically necessary (Unlimited)	70% up to 40 Days per Year	80% (Unlimited)	60% up to 40 Days per Year
Family Planning					
Sterilization					
Vasectomy	Place of Service Copay	Place of Service Copay	70%	80%	60%
Tubal Ligation	Place of Service Copay	Place of Service Copay	70%	80%	60%
Infertility Treatment	Diagnostic Services and Corrective Treatment Only	Diagnostic Services and Corrective Treatment Only	Covered In-Network Only	Diagnostic Services and Corrective Treatment Only	Covered In-Network Only
Dependent Children					
Unmarried and legally dependent upon employee and/or spouse	Covered to Age 19 Unless Full Time Student and Then Covered to Age 25-(Includes Missionaries)	Covered to Age 19 Unless Full Time Student and Then Covered to Age 25-(Includes Missionaries)		Covered to Age 19 Unless Full Time Student and Then Covered to Age 25-(Includes Missionaries)	

Note: Lifetime Maximum and Visits per year for Out of Network Services, cross-accumulates with In-Network.

The detailed benefit summaries provide a more comprehensive summary of benefits.

Revised 09/23/2003

CIGNA HEALTHCARE OF ARIZONA, 11001 N BLACK CANYON HWY ~~#200~~ 3RD FLOOR, PHOENIX, AZ 85029-4798

PRICING STEET S063202

Terms:	NET 30
Vendor Number:	**W000003050 X**
Telephone Number:	602/371-~~2669~~ **2530**
Fax Number:	602/~~371-2077~~ **861-8187**
Contact Person:	~~Brian Geroux Tim Thomas~~ **Peggy Beaver**
E-Mail (REP):	Peggy.Beaver@cigna.com
Certificates of Insurance	Required
Contract Period:	To cover the period ending ~~December 31, 2003 2004 2005~~ **June 30, 2007**.