Information You Need to Know

INTRODUCTION

Seton Insurance Company ("Seton") offers health plans to employers and employees in the Austin-Waco, Texas markets through a joint venture with Cigna Health and Life Insurance Company (Cigna) which are administered by QualCare, a Cigna company. Seton is a subsidiary of Seton Healthcare Family, a healing ministry of the Catholic Church. Seton and its affiliates do not promote or condone services, benefits or procedures that are contrary to or in conflict with the Ethical and Religious Directives for Catholic Health Care Services. Accordingly, Cigna offers the Reproductive Health plan covering those procedures or courses of treatment that do not comply with the Ethical and Religious Directives. Any such services will be processed solely by Cigna, under its exclusive authority and control.

TEXAS DEPARTMENT OF INSURANCE
Notice of Rights – Exclusive Provider Plans

An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.

You have the right to an adequate network of preferred providers (known as "network providers").

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

If your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the non-preferred provider's bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts.

You may obtain a current directory of preferred providers at the following website: **https://www.mysetoninsurance.com/Provider/** or by calling 1.844.883.2422 for assistance in finding available preferred providers. If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

TEXAS DEPARTMENT OF INSURANCE
Notice of Rights – Preferred Provider Plans

You have the right to an adequate network of preferred providers (also known as "network providers").

- If you believe that the network is inadequate, you may file a complaint with the Department of Insurance.
- If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

You have the right, in most cases, to obtain estimates in advance:

- From out-of-network providers of what they will charge for their services; and

- From your insurer of what they will pay for the services.

You may obtain a current directory of preferred providers at:
https://www.mysetoninsurance.com/Provider/ or by calling 1.844.883.2422 for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

- If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than $500 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website:
www.tdi.texas.gov/consumer/cpmmediation.html.

ADDITIONAL NOTICES

A current listing of contracted healthcare professionals can be obtained annually at no cost to you by contacting Customer Services at: 1.844.883.2422.

NOTICE: ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT.

UPDATING PROVIDER INFORMATION

Information contained in this online directory is updated six days per week, excluding holidays, Sundays, or interruptions due to system maintenance, upgrades or unplanned outages. This information is subject to change at any time. Providers may delay communicating to Seton and/or Cigna that they no longer accept new patients so we cannot guarantee that each provider is still accepting new patients. Please check with the health care professional before scheduling your appointment or receiving services or call Customer Service at the toll-free number on the back of your ID card to confirm he or she is participating in the Seton/Cigna network.

SOURCE OF INFORMATION AND FREQUENCY OF VALIDATION

Medical health care professional information addressing specialty, hospital affiliations, medical group affiliations, board certification, acceptance of new patients and languages spoken is obtained from an application that is completed and signed by the health care professional/facility (during credentialing). Physician board certification is validated through the American Board of Medical Specialties (ABMS), American Medical Association (AMA) or American Osteopathic

Association (AOA). Information on the application is updated when the medical health care professional/facility notifies Seton and/or Cigna of changes or at least every three years.

Some health care professionals share with Seton, Cigna and/or a third-party vendor the various languages spoken in their offices, and that information is published in this directory. The languages listed are not guaranteed and are not meant to meet any state or federal laws. Please call the health care professional to confirm the current languages spoken in their office.

REPORTING INACCURATE INFORMATION

If you see inaccurate information for a provider, please help us improve your experience by reporting it using one of the following options:

Report by phone: 1.844.883.2422

Report by e-mail: Send an e-mail to ***PDMCompliance@Cigna.com*** and include the following:

- Name, address and specialty of the provider as its currently displayed (this allows us to identify the provider you are referencing), and
- Information you believe is inaccurate, such as name (spelling), address, phone number, whether they are accepting new patients, or their participation in a certain network or benefit plan.

Cigna will verify the information you have sent and ensure it is corrected accordingly.

LANGUAGE ASSISTANCE

If you have difficulty understanding English, we offer language assistance and interpretation services at no cost to you. For help, please call the Customer Service number on the back of your ID card.

AYUDA CON EL IDIOMA: Si le cuesta comunicarse en inglés, ofrecemos asistencia de idioma y servicios de interpretación sin costo alguno para usted. Para obtener ayuda, comuníquese con el número de Servicio al cliente que figura en la parte de atrás de su tarjeta de identificación.

YOUR SUMMARY OF BENEFITS

Your *Summary of Benefits* gives you important information on the medical benefits and other types of services your plan covers. You should read your *plan documents* to determine whether you have prescription drug coverage, coverage for mental health and substance abuse, and/or vision care coverage as a part of your plan.

The information on this website only provides a general outline of your plan. For official plan coverage details, including what's covered, what's not covered and state government coverage requirements, please review official plan documents, such as: your insurance certificate, your plan booklet, policy or contract, your summary plan description. If there are any differences between these plan documents and the information on this page, your official plan documents are correct.

DEDUCTIBLE AND OUT-OF-POCKET EXPENSES

Out-of-network services are covered only up to your plan's Maximum Reimbursable Charge. This is the highest amount of money you can get reimbursed for. Anything above the Maximum Reimbursable Charge may come out of your pocket. If you visit an in-network health care professional, you get a discount. However, if you visit an out-of-network health care professional, you will only get paid up to a specific amount--your Maximum Reimbursable

IN-NETWORK VERSUS OUT-OF-NETWORK HEALTH CARE PROVIDERS

In-Network Costs

Selecting an in-network provider can reduce your out-of-pocket costs. That means other than your copayment, deductible or coinsurance amounts you should not be responsible for any costs for covered services when you receive them from an in-network provider. In-network providers should not bill you for any other costs for covered services or require you to pay any difference between their billed charges and what Cigna has paid them per their contract. If they do, this is called balance billing. You should not experience balance billing from an in-network provider for any covered service. The copayment, deductible or coinsurance is not considered balance billing.

Out-of-Network Costs

If your plan includes out-of-network benefits, your out-of-pocket costs may be higher for covered services from an out-of-network provider than if you had selected an in-network provider. If your plan does not include out-of-network coverage, the provider may bill you directly for the full cost of services and you will be responsible for the full costs except in the case of emergency services.

Change in Your Provider’s Network Status and Your Impacts

It is important to check that your provider is still in your plan’s network before receiving care. If your provider has a change in participation status and is no longer in-network, you may be subject to the same out-of-pocket, out-of-network costs described above. If you are currently being treated for specific ongoing conditions or are pregnant, continuity of care coverage may be considered for a defined period of time. You must apply for Continuity of Care using the Continuity of Care/Transition of Care Request Form located at **www.mysetoninsurance.com.** Please check your benefit plan description or call Customer Service at the toll-free number on the back of your ID card.

Out-of-Network Reimbursement

Payments made to providers not participating in your Reproductive Health network are in line with industry standards and are based on: the provider’s charges, comparison of charges by other similar providers, and the fees typically paid to an in-network provider, for the same type of covered service in the same geographic region and Medicare reimbursement rates. The fee paid to an out-of-network provider by Cigna is considered to be the Maximum Reimbursable Charge. The out-of-network provider may bill you the difference between their charge and the Maximum Reimbursable Charge in addition to applicable deductibles, copayments and coinsurance.

Providers at In-Network Facilities

Health care services may be provided to you at an in-network health care facility by facility-based providers (such as anesthesiologist, radiologists, and laboratories) who are not in your plan's network. You may be responsible for payment of all or part of the costs for those out-of-network services in addition to applicable amounts due for copayments, coinsurance, deductibles and non-covered services.

For more information or to determine if a provider is in-network, please call Customer Service at the toll-free number on the back of your ID card.

DIRECT ACCESS TO OBSTETRICIANS AND GYNECOLOGISTS

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

PRECERTIFICATION

Our goal is to help make sure that you have access to the appropriate care, in the appropriate setting. We have established a wide network of doctors and we continuously contract with new health care professionals to help make sure that you have access to care from credentialed health care professionals.

What is Precertification?

Precertification is a review process where nurses, pharmacists and/or doctors work with your doctor to determine:

- Whether a procedure, treatment or service is covered by your plan.
- What your coverage will be for a procedure, treatment or service if you use a health care professional who is not in the Cigna network?

How Does The Process Work?

Your plan may require precertification for hospital admissions and selected outpatient services. When precertification is required, an utilization review nurse evaluates the request using nationally recognized guidelines. These guidelines are consistent with sound clinical principles and processes and have been developed with involvement from actively practicing health care professionals. Nurses will determine what services are covered based on your plan and using these guidelines. When guidelines do not exist, clinical resource tools based on clinical evidence are used.

Anytime a nurse is unable to approve coverage for clinical reasons, the case is referred to a Cigna doctor who considers each case on an individual basis. The Cigna doctor may speak with your doctor to obtain additional information. You and your doctor will be notified in writing if a

request for a precertification number cannot be approved based on the information we received and your plan benefits.

When Does The Review Occur?

The review process can occur at three different times:

- Prospective review is when QualCare receives a request before you receive care. Determinations are made within two business days of receiving all necessary information. You and your health care professional will be notified verbally or electronically and by mail.

- Concurrent review is when QualCare receives a request while you are receiving care or in a hospital, skilled nursing facility or rehabilitation facility. Determinations are made within one business day of receiving all necessary information. You and your health care professional will be notified verbally or electronically and by mail.

- Retrospective review is when QualCare receives a request after you have received care. Determinations related to these services are made within thirty days after receiving all necessary information. You and your health care professional will be notified verbally or electronically and by mail.

If your situation requires that a determination is made right away, then QualCare will perform a quick review. This determination will be completed within one business day. Licensed doctors will determine coverage denials when clinical reasons are the reason for the denial. Denial letters will explain the reason for the decision and details on how to submit additional information and/or proceed through the formal Appeals Process, if you disagree with the coverage decision.

If your doctor is part of the Cigna network, then he or she is responsible for contacting QualCare to start the precertification process. If you use a doctor who is not part of the Cigna network, then you are responsible for contacting QualCare to start the precertification process. It is important for you to review your benefit plan or contact QualCare at the number on your ID card to understand which services require precertification.

PROVIDER COMPENSATION

Cigna is committed to keeping you informed about matters related to your health care plan. For that reason, we offer the following description of the way that Cigna compensates health care professionals (physicians, hospitals and other health care practitioners and facilities) that participate in our networks. Cigna compensates health care professionals in ways that are intended to emphasize preventive care, promote quality care and ensure the appropriate and cost-effective use of covered medical services and supplies. Cigna reinforces this philosophy through utilization management decisions made by its medical director and medical management staff. Cigna employees are encouraged to promote appropriate utilization of covered health care services and to discourage underutilization. The methods by which participating health care professionals agree to be compensated are described generally here. The amount and type of compensation a health care professional agrees to accept may vary depending upon the type of plan. For example, a hospital may agree to accept less for services provided to patients enrolled in an HMO plan than to patients enrolled in other types of plans. In addition, Cigna may attempt in various ways to promote the use of participating health care professionals based upon quality and cost-effectiveness measures while assuring quality and access to covered services and supplies.

Discounted Fee-for-Service

Payment for services is based on an agreed-upon discounted amount from the health care professional's bill.

Capitation

By mutual agreement, network physicians, physician/hospital organizations ("PHOs") or other health care professional groups are paid a fixed amount (capitation) at regular intervals for each individual assigned to the physician, PHO or other health care professional groups, whether or not services are provided. This payment covers physician and/or, where applicable, hospital or other services covered under the benefits plan. Health care professional groups and PHOs may in turn compensate health care professionals using a variety of methods. Capitation can offer health care professionals a predictable income, encourage physicians to keep people well through preventive care, eliminate the financial incentive to provide services that will not benefit the patient and reduce paperwork. Cigna may also work with third parties that provide network management services. Under these arrangements, Cigna pays the third party a fixed monthly amount per individual for these services. Health care professionals are compensated by the third party for services provided to Cigna plan participants from the fixed amount. Compensation arrangements are agreed upon by the third parties and their contracted health care professionals, and may include discounted fee for service and capitation. Some health care professionals and third parties that provide network management services may participate in a risk-sharing arrangement with Cigna; they agree on a target amount for the cost of certain services and share all or some of the amount by which costs are over or under the target. Services are monitored using criteria that may include accessibility, quality of care, customer satisfaction and appropriate and cost-effective use of medical services and supplies.

Bonuses and Incentives

Some health care professionals may receive additional payments based on their performance, which is measured using criteria that may include quality of care, quality of service and appropriate and cost-effective use of medical services and supplies. Health care professionals may also receive financial and/or nonfinancial incentives that promote utilization of cost-effective participating health care professionals (such as hospitals, labs, specialists and vendors) and covered drugs and supplies.

Per Diem

A specific amount is paid to a hospital per day for all health care received. The per diem payment may vary by type of service and length of stay and the payment may in some cases be greater than the hospital's normal billed charges.

Case Rate

A specific amount is paid for all health care received in the hospital for a given hospital stay (such as for a normal maternity delivery). If you would like to find out which compensation method applies to services you receive from a health care professional, just ask the doctor's administrative staff. Customer Service is available to help with general questions at the toll-free telephone number on your ID card.

SOCIAL SECURITY NUMBER PROTECTION POLICY

We take our obligation to protect your Social Security number ("SSN") seriously. This notice applies to any SSN that Cigna and its affiliates collect in the course of business. It is our policy to protect the confidentiality of SSNs by implementing administrative, physical and technical safeguards that are designed to guard against unauthorized access to SSNs. It is also our policy to limit access to SSNs to that which is allowed by applicable law and to prohibit the unlawful disclosure of SSNs.

SERVICE AREA

Participating health care professionals are located throughout the Texas service area. The thirteen (13) county service area consists of the following counties:

Bastrop	**Coryell**	**Hill**	**Williamson**
Bell	**Falls**	**Limestone**	
Bosque	**Hamilton**	**McLennan**	
Burnet	**Hays**	**Travis**	

Look under specific listings at this website for the addresses of physicians and hospitals that participate in the Cigna network.