Palm Beach County Board of
County Commissioners

POINT OF SERVICE MEDICAL
BENEFITS

EFFECTIVE DATE: January 1, 2020

ASO35
3212040

This document printed in October, 2020 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
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Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY PALM BEACH COUNTY BOARD OF COUNTY COMMISSIONERS WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

HC-NOT89
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.
Special Plan Provisions

Case Management

Case Management is a service provided through a Review Organization, 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 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.

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, mental health, 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.

- You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on 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.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- 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.
- 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.
- 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).
- 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).
- 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.

HC-SPP2 04-10 V1

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well being of our members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

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Notice Regarding Emergency Services and Urgent Care

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 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 24 hours a day, seven days a week to assist you when you need Emergency Services.
If you receive Emergency Services outside the service area, you must notify the Review Organization as soon as reasonably possible. The Review Organization 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.

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 Review Organization.

Urgent Care Outside the Service Area
In the event you need Urgent Care while outside the service area, you should, whenever possible, contact your PCP for direction and authorization prior to receiving services.

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 by the Review Organization.

Important Notices

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

Selection of a Primary Care Provider
This plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, Cigna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

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

Important Information
Rebates and Other Payments
Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals covered under your plan and Prescription Drug Products included on the Prescription Drug List. These rebates or remuneration are not obtained on you or your Employer’s or plan’s behalf or for your benefit. Cigna, its affiliates and the plan are not obligated to pass these rebates on to you, or apply them to your plan’s Deductible if any or take them into account in determining your Copayments and/or Coinsurance. Cigna and its affiliates or designees, conduct business with various pharmaceutical manufacturers separate and apart from this plan’s Medical Pharmaceutical and Prescription Drug Product benefits. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this plan. Cigna and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.

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

Cigna:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  • Qualified sign language interpreters
  • Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as
  • Qualified interpreters
  • Information written in other languages
If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)


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Proficiency of Language Assistance Services

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

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

**Chinese** – 请注意，我们为您提供免费的语言协助服务。对于Cigna的现有客户，请致电您的ID卡背面的号码。其他客户请致电1.800.244.6224（视障专线：请拨打711）。

**Vietnamese** – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Để liên hệ với Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

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


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

**Arabic** – طلب الاحترام خدمات الترجمة المجانية متوفرة للعملاء

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

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

**French Creole** – ATANSYON: Gen sèvis éd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimo yo kò te dëyè kat ID ou. Sinon, rele nimo 1.800.244.6224 (TTY: Rele 711).

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

myCigna.com
Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) - Non-Quantitative Treatment Limitations (NQTLs)

Federal MHPAEA regulations provide that a plan cannot impose a Non-Quantitative Treatment Limitation (NQTL) on mental health or substance use disorder (MH/SUD) benefits in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, those used in applying the NQTL to medical/surgical benefits in the same classification of benefits as written and in operation under the terms of the plan.

Non-Quantitative Treatment Limitations (NQTLs) include:

- Medical management standards limiting or excluding benefits based on Medical Necessity or whether the treatment is experimental or investigative;
- Prescription drug formulary design;
- Network admission standards;
- Methods for determining in-network and out-of-network provider reimbursement rates;
- Step therapy a/k/a fail-first requirements; and
- Exclusions and/or restrictions based on geographic location, facility type or provider specialty.

A description of your plan’s NQTL methodologies and processes applied to medical/surgical benefits and MH/SUD benefits is available for review by Plan Administrators (e.g. employers) and covered persons by accessing the appropriate link below:

**Employers (Plan Administrators):**
https://cignaaccess.cigna.com/secure/app/ca/centralRepo
Log in, select Resources and Training, then select the NQTL document.

**Covered Persons:**  [www.cigna.com](http://www.cigna.com)
To determine which document applies to your plan, select the relevant health plan product; medical management model (inpatient only or inpatient and outpatient) which can be located in this booklet immediately following The Schedule; and pharmacy coverage (whether or not your plan includes pharmacy coverage).

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**How To File Your Claim**

There’s no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by calling Member Services using the toll-free number on your identification card.

**CLAIM REMINDERS**

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA’S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.
- YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON
YOUR BENEFIT IDENTIFICATION CARD.

BE SURE TO FOLLOW THE INSTRUCTIONS LISTED
ON THE BACK OF THE CLAIM FORM CAREFULLY
WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims
Cigna will consider claims for coverage under our plans when
proof of loss (a claim) is submitted within 365 days for Out-
of-Network benefits after services are rendered. If services are
rendered on consecutive days, such as for a Hospital
Confinement, the limit will be counted from the last date of
service. If claims are not submitted within 365 days for Out-
of-Network benefits, the claim will not be considered valid
and will be denied.

WARNING: Any person who knowingly and with intent to
defraud any insurance company or other person files an
application for insurance or statement of claim containing any
materially false information; or conceals for the purpose of
misleading, information concerning any material fact thereto,
commits a fraudulent insurance act.

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
The waiting period is defined as the period commencing with the
employee's date of employment and ending with the first
day of the calendar month coinciding with or next following
60 consecutive days of employment.

Classes of Eligible Employees
Each Employee as reported to the insurance company by your
Employer excluding California residents.

Effective Date of Employee Insurance
You will become insured on the date you elect the insurance
by signing an approved payroll deduction or
completing the enrollment process, as applicable, but no earlier than the date
you become eligible.
You will become insured on your 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.

Dependent Insurance
For your Dependents to be insured, you will have to pay the
required contribution, if any, toward 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 (if required), but no earlier than the day you become
eligible for Dependent Insurance. All of your Dependents as
defined will be included. A newborn child will be covered for the
first 31 days of life even if you fail to enroll the child. If
you enroll the child after the first 31 days and by the 60th day
after his birth, coverage will be offered at an additional
premium. Coverage for an adopted child will become effective
from the date of placement in your home or from birth for the
first 31 days even if you fail to enroll the child. However, if
you enroll the adopted child between the 31st and 60th days
after his birth or placement in your home, coverage will be
offered at an additional premium.
Your Dependents will be insured only if you are insured.
Newborn Children

Coverage for newborn children of an insured employee or the employee’s covered family member begins from the moment of birth.

Coverage for a newborn child of a covered family member terminates when the child is 18 months old.

If notice of birth is given to the company within 30 days there is no premium charge for the initial 30 day period. If notice is given within 60 days of the birth of the child, the insurer may not deny coverage for a child due to the failure of the insured to timely notify the insurer of the birth of the child.

This policy covers newborn children for the necessary dental care or dental treatment of congenital defects or birth abnormalities of the teeth or gums.

Foster Children, Adoptive Children and Children in Custodial Care

Benefits applicable to children of the insured employee also apply to adoptive children, foster children and children in custodial care. Coverage begins from birth or from the moment of placement in the home. Coverage may not exclude any preexisting condition of the child.

In the case of a newborn adoptive child, coverage begins from the moment of birth if there is a written agreement to adopt the child, whether or not the agreement is enforceable.

Coverage does not extend to an adoptive child who is not ultimately placed in the home of the insured employee.

If notice of the birth or placement of an adopted child is given to the company within 30 days there is no premium charge for the initial 30 day period.

If notice is given within 60 days of the birth or placement of an adopted child, the insurer may not deny coverage for the child due to the failure of the insured to timely notify the insurer of the birth or placement of the child.

If any family member of the insured employee is covered as a dependent, then benefits applicable to children are covered with respect to a foster child or other child in court-ordered temporary custody or other custody of the insured employee.

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent 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.

If notice is given within 60 days of the birth of the child, the insurer may not deny coverage for a child due to the failure of the insured to timely notify the insurer of the birth of the child.

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Primary Care Physician

Choice of Primary Care Physician:

When you elect Medical Insurance, you will select a Primary Care Physician for yourself and your Dependents from a list provided by Cigna. The Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Primary Care Physician's Role/Your Responsibility:

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents. You and your Dependents are responsible for contacting and obtaining the authorization of the Primary Care Physician, as required, prior to seeking medical care. (You are responsible for obtaining such authorization on behalf of a Dependent who is a minor.)

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent; will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

Direct Access for OB/GYN Services

Female insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for covered OB/GYN services. There is no requirement to obtain an
authorization of care from your Primary Care Physician for visits to the Participating Provider of your choice for pregnancy, well-woman gynecological exams, primary and preventive gynecological care, and acute gynecological conditions.

**Direct Access for Mental Health and Substance Use Disorder Services**

Insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for covered Mental Health and Substance Use Disorder Services. There is no requirement to obtain an authorization of care from your Primary Care Physician for individual or group therapy visits to the Participating Provider of your choice for Mental Health and Substance Use Disorder Services.

**Direct Access for Dermatologist**

Individuals covered by this plan may have direct access to any participating dermatologist for a maximum of 5 visits per contract year without an authorization of care. The 5 visits do not have to be with the same provider. Any additional visits will require authorization. Included in this benefit are management of the dermatologic condition as well as minor procedures. All other procedures that are not minor, will require prior authorization.

**Direct Access for a Chiropractor or Podiatrist:**

Individuals covered by this plan may have direct access to any participating chiropractor or podiatrist without the need for prior authorization.
Point of Service Medical Benefits
The Schedule

For You and Your Dependents
Point of Service Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Point of Service Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment Amount or Deductible or Coinsurance.

When you receive services from an In-Network Provider, remind your provider to utilize In-Network Providers for x-rays, lab tests and other services to ensure the cost may be considered at the In-Network level.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services when approved will be covered at the In-Network benefit level.

Coinsurance
The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

Copays
Copays are expenses to be paid by you or your Dependent for covered services.

Out-of-Pocket Expenses - For In-Network Charges Only
Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayment Amounts or Coinsurance. When the Out-of-Pocket Maximum shown in The Schedule is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

Out-of-Pocket Expenses - For Out-of-Network Charges Only
Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%:

- Coinsurance.
- Any coinsurance, Copays and/or benefit deductibles for the following:
  - inpatient hospital facility.

Once the Out-of-Pocket Maximum is reached for covered services that apply to the Out-of-Pocket Maximum, any Copays and/or benefit deductibles are no longer required.

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Non-compliance penalties.
- Plan Deductible.
- Any Copays and/or benefit deductibles not listed above as accumulating to the Out of Pocket maximum.
- Provider charges in excess of the Maximum Reimbursable Charge.
**Point of Service Medical Benefits**

**The Schedule**

**Accumulation of Plan Out-of-Pocket Maximums**
Out-of-Pocket Maximums will accumulate in one direction (that is, Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted. All In-Network services must be performed by the Primary Care Physician (PCP), referred by the PCP or approved by the local Healthplan.

**Accumulation of Pharmacy Benefits**
If your plan provides Pharmacy benefits separately, any In-Network medical Out-of-Pocket Maximums will cross accumulate with any In-Network Pharmacy Out-of-Pocket Maximums.

**Contract Year**
Contract Year means a twelve month period beginning on each 01/01.

**Guest Privileges**
If you or one of your Dependents will be residing temporarily in another location where there are In-Network Providers, you may be eligible for Point of Service Medical Benefits at that location. However, the benefits at the host location may differ from those described in this certificate. Refer to your Benefit Summary from the host location or contact your Employer for more information.

**Multiple Surgical Reduction (Out-of-Network)**
Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

**Assistant Surgeon and Co-Surgeon Charges**

**Assistant Surgeon**
The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

**Co-Surgeon**
The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

**Out-of-Network Emergency Services Charges**
1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan’s benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greatest of the following, not to exceed the provider’s billed charges: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td></td>
<td>Unlimited</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>The Percentage of Covered Expenses the Plan Pays</strong></td>
<td>100%</td>
<td>70% of the Maximum Reimbursable Charge</td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td>&quot;No charge&quot; means an insured person is not required to pay Coinsurance.</td>
<td></td>
</tr>
<tr>
<td><strong>Maximum Reimbursable Charge</strong></td>
<td>Not Applicable</td>
<td>80th Percentile</td>
</tr>
<tr>
<td>Maximum Reimbursable Charge is determined based on the lesser of the provider’s normal charge for a similar service or supply; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td>The provider may bill you for the difference between the provider’s normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, Copayment Amounts and coinsurance.</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td>Some providers forgive or waive the cost share obligation (e.g. your copayment, deductible and/or coinsurance) that this plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this plan. For more details, see the Exclusions Section.</td>
<td></td>
</tr>
</tbody>
</table>
## Benefit Highlights

<table>
<thead>
<tr>
<th>Calendar Year Deductible</th>
<th>In-Network</th>
<th>Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Not Applicable</td>
<td>$500 per person</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-Pocket Maximum</th>
<th>Individual</th>
<th>Family Maximum</th>
<th>Family Maximum Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,500 per person</td>
<td>$5,000 per family</td>
<td>Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$3,000 per person</td>
<td>$6,000 per family</td>
<td>- pharmacy copayments.</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$3,000 per person</td>
<td>$6,000 per family</td>
<td>- vision copayments.</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$3,000 per person</td>
<td>$6,000 per family</td>
<td>- non-compliance penalties.</td>
</tr>
</tbody>
</table>

### Individual Calculation:
Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.

### Physician’s Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>No charge after $20 per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visits</td>
<td>No charge after $40 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
</tbody>
</table>

**Note:**
OB/GYN provider is considered a Specialist.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery Performed in the Physician’s Office</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Second Opinion Consultations (provided on a voluntary basis)</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Allergy Treatment/Injections</td>
<td>No charge after either the $20 PCP or $40 Specialist per office visit copay or the actual charge, whichever is less</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Allergy Serum (dispensed by the Physician in the office)</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Medical Telehealth</td>
<td>No charge</td>
<td>In-Network coverage only</td>
</tr>
</tbody>
</table>
## BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.</td>
<td></td>
<td>70% (no plan deductible)</td>
</tr>
<tr>
<td>Routine Preventive Care (for children to age 16)</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td>Immunizations (for children to age 16)</td>
<td>No charge</td>
<td>70% (no plan deductible)</td>
</tr>
<tr>
<td>Routine Preventive Care (for ages 16 and over)</td>
<td>No charge</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Immunizations (for ages 16 and over)</td>
<td>No charge</td>
<td>In-Network coverage only</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mammograms, PSA, PAP Smear</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Related Services (i.e. “routine” services)</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Diagnostic Related Services (i.e. “non-routine” services)</td>
<td>Subject to the plan’s x-ray &amp; lab benefit; based on place of service</td>
<td>Subject to the plan’s x-ray &amp; lab benefit; based on place of service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Hospital - Facility Services</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: Per admission Copayment Amount waived if re-admitted for the same condition within 30 days.</td>
<td>$500 per admission deductible, then 70% after plan deductible</td>
<td></td>
</tr>
<tr>
<td>Semi-Private Room and Board</td>
<td>Limited to the semi-private room negotiated rate</td>
<td>Limited to the semi-private room rate</td>
</tr>
<tr>
<td>Private Room</td>
<td>Limited to the semi-private room negotiated rate</td>
<td>Limited to the semi-private room rate</td>
</tr>
<tr>
<td>Special Care Units (ICU/CCU)</td>
<td>Limited to the negotiated rate</td>
<td>Limited to the ICU/CCU daily room rate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Facility Services</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: The facility copay will apply as long as services billed include one or more of the facility room charges listed above.</td>
<td>70% after plan deductible</td>
<td></td>
</tr>
<tr>
<td>Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room</td>
<td>No charge after $150 per visit copay</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Hospital Physician’s Visits/Consultations</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>No charge</td>
<td></td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>--------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Professional Services</strong></td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Professional Services</strong></td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Services</strong></td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay No charge after $25 per visit copay (Copay waived if admitted)</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay No charge after $25 per visit copay (Copay waived if admitted)</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after $20 PCP or $40 Specialist per office visit copay No charge after $25 per visit copay (Copay waived if admitted)</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay No charge after $25 per visit copay (Copay waived if admitted)</td>
</tr>
<tr>
<td>Urgent Care Facility or Outpatient Facility</td>
<td>No charge after $20 PCP or $40 Specialist per office visit copay No charge after $25 per visit copay (Copay waived if admitted)</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay No charge after $25 per visit copay (Copay waived if admitted)</td>
</tr>
<tr>
<td>Outpatient Professional Services (radiology, pathology, physician)</td>
<td>No charge after $20 PCP or $40 Specialist per office visit copay No charge after $25 per visit copay (Copay waived if admitted)</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay No charge after $25 per visit copay (Copay waived if admitted)</td>
</tr>
<tr>
<td>X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit)</td>
<td>No charge after $20 PCP or $40 Specialist per office visit copay No charge after $25 per visit copay (Copay waived if admitted)</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay No charge after $25 per visit copay (Copay waived if admitted)</td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)</td>
<td>No charge after $20 PCP or $40 Specialist per office visit copay No charge after $25 per visit copay (Copay waived if admitted)</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay No charge after $25 per visit copay (Copay waived if admitted)</td>
</tr>
<tr>
<td>The scan copay applies per type of scan per day</td>
<td>No charge after $20 PCP or $40 Specialist per office visit copay No charge after $25 per visit copay (Copay waived if admitted)</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay No charge after $25 per visit copay (Copay waived if admitted)</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>No charge after $200 per visit copay (Copay waived if admitted Note: No charge if re-admitted (in hospital) for same illness within 30 days)</td>
<td>No charge after $200 per visit copay (Copay waived if admitted Note: No charge if re-admitted (in hospital) for same illness within 30 days)</td>
</tr>
<tr>
<td>Outpatient Professional Services (radiology, pathology, ER physician)</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>X-ray and/or Lab performed at the Emergency Room Facility (billed by the facility as part of the ER visit)</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Independent X-ray and/or Lab Facility in conjunction with an ER visit</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)</td>
<td>No charge</td>
<td>No charge after $150 scan copay</td>
</tr>
<tr>
<td>The scan copay applies per type of scan per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Inpatient Services at Other Health Care Facilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</td>
<td>No charge</td>
<td>$500 per admission deductible, then 70% after plan deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum: 90 days combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No prior hospitalization required</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Laboratory Services (includes pre-admission testing)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient Hospital Facility</td>
<td>No charge for facility charges; no charge for outpatient professional charges</td>
<td>No charge for facility charges; no charge for outpatient professional charges</td>
</tr>
<tr>
<td>Independent Lab Facility</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Radiology Services (includes pre-admission testing)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Hospital Facility</td>
<td>No charge for facility charges; no charge for outpatient professional charges</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Independent X-ray Facility</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The scan copay/deductible applies per type of scan per day. Additional copayments for other services rendered may apply subject to place of service bounds.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after $150 scan copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No charge after $150 scan copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td><strong>Advanced Heart Imaging (i.e MRI, MRA, CAT Scan or PET Scan done in conjunction with nuclear stress test or other advanced heart imaging)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The scan copay applies per type of scan per day. Additional copayments for other services rendered may apply subject to place of service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>$40 copay and $150 scan copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No charge after $150 scan copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td><strong>Outpatient Therapy Services and Chiropractic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Chiropractic Therapy (includes Chiropractors)</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td><strong>Note:</strong> The Outpatient Therapy Services copay does not apply to services provided as part of a Home Health Care visit. <strong>Note:</strong> Chiropractic therapy and services are not subject to medical necessity review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Network Calendar Year Maximum: 100 days (includes outpatient private nursing when approved as medically necessary)</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>(The limit is not applicable to Mental Health and Substance Use Disorder conditions.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td><strong>Bereavement Counseling</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services provided as part of Hospice Care</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Inpatient</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Services provided by Mental Health Professional</td>
<td>Covered under Mental Health benefit</td>
<td>Covered under Mental Health benefit</td>
</tr>
<tr>
<td><strong>Maternity Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Visit to Confirm Pregnancy Note: OB/GYN provider is considered a Specialist.</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>All subsequent Prenatal Visits, Prenatal Visits and Physician’s Delivery Charges (i.e. global maternity fee)</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Delivery - Facility (Inpatient Hospital, Birthing Center)</td>
<td>No charge after $350 per admission copay</td>
<td>$500 per admission deductible, then 70% after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>----------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td><strong>Women’s Family Planning Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit (tests, counseling)</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes coverage for contraceptive devices (e.g., Depo-Provera and Intruterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician’s office. Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td><strong>Men’s Family Planning Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit, Lab and Radiology Tests and Counseling</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Surgical Sterilization Procedures for Vasectomy (excludes reversals)</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge after $350 per admission copay</td>
<td>$500 per admission deductible, then 70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No charge after $150 per visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
</tbody>
</table>
## BENEFIT HIGHLIGHTS

### In-Network

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office Visit (Lab and Radiology Tests, Counseling)</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Surgical Procedure Copay</td>
<td>$200 Surgical Copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge after $350 per admission copay</td>
<td>$500 per admission deductible, then 70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No charge after $150 per visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
</tbody>
</table>

### Out-of-Network

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office Visit (Lab and Radiology Tests, Counseling)</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Surgical Procedure Copay</td>
<td>$200 Surgical Copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge after $350 per admission copay</td>
<td>$500 per admission deductible, then 70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No charge after $150 per visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
</tbody>
</table>

### Organ Transplants

Includes all medically appropriate, non-experimental transplants

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge after $350 per admission copay</td>
<td>$500 per admission deductible, then 70% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Physician’s Services</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Lifetime Travel Maximum:</td>
<td>No charge (only available when using LifeSOURCE facility)</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>$10,000 per transplant</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Durable Medical Equipment

Calendar Year Maximum: Unlimited

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>No charge</td>
<td></td>
<td>$200 DME deductible per Calendar Year, then 100%</td>
</tr>
</tbody>
</table>

### Breast Feeding Equipment and Supplies

Note: Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>No charge</td>
<td></td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td><strong>External Prosthetic Appliances</strong></td>
<td>No charge</td>
<td>70%</td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diabetic Equipment</strong></td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nutritional Evaluation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 visits per person however, the 3 visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>visit limit will not apply to treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of diabetes, mental health and substance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>use disorder conditions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $20 PCP or $40</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>Specialist per office visit copay</td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge after $350 per admission</td>
<td>$500 per admission deductible, then</td>
</tr>
<tr>
<td></td>
<td>copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No charge after $150 per visit copay</td>
<td></td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td><strong>Genetic Counseling</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 visits per person for Genetic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling for both pre- and post-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>genetic testing; however, the 3 visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>limit will not apply to Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Substance Use Disorder conditions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge after $350 per admission</td>
<td>$500 per admission deductible, then</td>
</tr>
<tr>
<td></td>
<td>copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No charge after $150 per visit copay</td>
<td></td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td><strong>Dental Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to charges made for a continuous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>course of dental treatment started</td>
<td></td>
<td></td>
</tr>
<tr>
<td>within six months of an injury to teeth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $20 PCP or $40</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>Specialist per office visit copay</td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge after $350 per admission</td>
<td>$500 per admission deductible, then</td>
</tr>
<tr>
<td></td>
<td>copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No charge after $150 per visit copay</td>
<td></td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------</td>
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</tr>
<tr>
<td>Acupuncture</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copayment amount</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Note: If deemed medically necessary for certain conditions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TMJ Surgical and Non-Surgical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always excludes appliances and orthodontic treatment. Subject to medical necessity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay</td>
<td>70%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge after $350 per admission copay</td>
<td>$500 per admission deductible, then 70%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No charge after $150 per visit copay</td>
<td>70%</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>No charge</td>
<td>70%</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Covered when medically necessary. Subject to any limitations shown in the “Exclusions, Expenses Not Covered and General Limitations” section of this certificate. Additional Copayments for other services rendered may apply subject to place of service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $20 PCP or $40 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge after $350 per admission copay</td>
<td>$500 per admission deductible, then 70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No charge after $150 per visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Routine Foot Disorders</td>
<td>Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.</td>
<td>Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.</td>
</tr>
<tr>
<td>Treatment Resulting From Life Threatening Emergencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------</td>
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</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>No charge after $350 per admission (Copay waived if re-admitted for same condition within 30 days)</td>
<td>$500 per admission deductible, then 70% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>$40 per visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>100%</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient - Office Visits</td>
<td>Includes individual, family and group psychotherapy; medication management, Behavioral Telehealth consultation, etc.</td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>Outpatient - All Other Services</td>
<td>Includes Partial Hospitalization, Intensive Outpatient Services, Behavioral Telehealth consultation, etc.</td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>No charge after $350 per admission</td>
<td>$500 per admission deductible, then</td>
</tr>
<tr>
<td></td>
<td>(Copay waived if re-admitted for same</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>condition within 30 days)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient - Office Visits</td>
<td>$40 per visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Includes individual, family and group psychotherapy; medication management, Behavioral Telehealth consultation, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient - All Other Services</td>
<td>100%</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Includes Partial Hospitalization, Intensive Outpatient Services, Behavioral Telehealth consultation, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Point of Service Medical Benefits

Certification Requirements - Out-of-Network
For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient, except for 48/96 hour maternity stays;
- for Mental Health or Substance Use Disorder Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will not include the first $500 of Hospital charges made for each separate admission to the Hospital unless PAC is received prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred will not include the first $500 of Hospital charges made for each separate admission to the Hospital unless PAC is received prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will be reduced by 50%:

- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

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.

Outpatient Certification Requirements – Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-Standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or outpatient procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should only be requested for non-emergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will not include the first $500 for charges made for any outpatient diagnostic testing or outpatient procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will be reduced by 50% for charges made for outpatient diagnostic testing or outpatient procedures for which Outpatient Certification was performed, but, 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.

Outpatient Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Home Health Care Services.
- Medical Pharmaceuticals.
- Radiation Therapy.

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy. Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays.
• inpatient services at any participating Other Health Care Facility.
• residential treatment.
• outpatient facility services.
• partial hospitalization.
• intensive outpatient programs.
• advanced radiological imaging.
• non-emergency ambulance.
• certain Medical Pharmaceuticals.
• home health care services.
• radiation therapy.
• transplant services.
• charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
• charges made for Emergency Services and Urgent Care.
• charges made by a Physician or a Psychologist for professional services.
• charges made by a Nurse, other than a member of your family or your Dependent’s family, for professional nursing service.
• charges made for anesthesics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
• charges made for an annual prostate-specific antigen test (PSA).
• charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
• charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
• charges made for the following preventive care services (detailed information is available at www.healthcare.gov.):
  (1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;
  (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the covered person involved;
  (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
  (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Covered Expenses
The term Covered Expenses means expenses incurred by a person while covered under this plan for the charges listed below for:
• preventive care services; and
• services or supplies that are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna.

As determined by Cigna, Covered Expenses may also include all charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

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 Limit 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 for medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered for an established medical condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Penile implants are not covered as treatment of psychogenic erectile dysfunction.

• charges made for surgical or non-surgical treatment of Temporomandibular Joint Dysfunction.

• charges made for acupuncture.

• coverage for diagnosis and treatment of autism spectrum disorder to include autistic disorder, Asperger's Syndrome and pervasive developmental disorder not otherwise specified, when prescribed by a treating Physician in accordance with a treatment plan for individuals diagnosed at age 8 or younger. Coverage is provided for Dependents to age 18, or older if attending High School. Treatment includes well-baby and well-child screening for diagnosis and treatment through speech therapy, occupational therapy, physical therapy and applied behavior analysis. Day or visit maximums applied to such treatment for other causes will not apply to treatment of autism spectrum disorder.

• charges made by a Physician, certified diabetes educator or licensed dietitian for a program which provides instruction on an outpatient basis for a person who has been diagnosed as having diabetes, for the purpose of instructing such person about the condition and its control;

• includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, including telephones and internet, when delivered through a contracted medical telehealth provider.

• charges for general anesthesia and hospitalization services for dental procedures for an individual who is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.

• charges made for 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.

• charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.

In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below, for a Dependent child who is age 15 or less, for charges made for Child Preventive Care Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

• a history;

• physical examination;

• development assessment;

• anticipatory guidance; and

• appropriate immunizations and laboratory tests; excluding any charges for:

• more than one visit to one provider for Child Preventive Care Services at each of the Approximate Age Intervals, up to a total of 18 visits for each Dependent child;

• services for which benefits are otherwise provided under this Covered Expenses section;

• services for which benefits are not payable, according to the Expenses Not Covered section.

• It is provided that any Copayment that would otherwise apply will be waived for those Covered Expenses incurred for Child Preventive Care Services. Approximate Age Intervals are: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years and 15 years.

• charges for the treatment of cleft lip and cleft palate including medical, dental, orthodontia, speech therapy, audiology and nutrition services, when prescribed by a Physician.

• charges for newborn and infant hearing screening as well as any medically necessary follow-up evaluations leading to diagnosis and subsequent medically necessary treatment of a diagnosed hearing impairment.

• charges for newborn and infant hearing screening and Medically Necessary follow-up evaluations. When ordered by the treating Physician, a newborn’s hearing screening must include auditory brainstem responses or evoked otoacoustic emissions or other appropriate technology approved by the FDA. All screenings shall be conducted by a licensed audiologist, Physician, or supervised individual who has training specific to newborn hearing screening. Newborn means an age range from birth through 29 days. Infant means an age range from 30 days through 12 months.

• charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: have vertebral abnormalities; are receiving long-term glucocorticoid (steroid) therapy; have primary hyperparathyroidism; have a family history of osteoporosis;
and/or are estrogen-deficient individuals who are at clinical risk for osteoporosis.

- charges made for diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint.
- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be Medically Necessary by the Physician and in consultation with the patient. Postoperative follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.
- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: a baseline mammogram for women ages 35 through 39; a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; a mammogram every year for women age 50 and over; and one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician's recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.
- charges for the coverage of child health supervision services from birth to age 16. Child health supervision services are physician-delivered or supervised services that include periodic visits which include a history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests.
- charges for the treatment of Down syndrome through speech therapy, occupational therapy, physical therapy and applied behavioral analysis. Includes habilitative and rehabilitative services.
- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.

Covered Expenses – Mental Health and Substance Use Disorder

- behavioral consultations and services via secure telecommunications technologies that shall include video capability, including telephones and internet, when delivered through a behavioral provider.

Clinical Trials

This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

(b) either

- the referring health care professional is a participating health care provider and has concluded that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

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

The clinical trial must meet the following requirements:

The study or investigation must:

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

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

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

Routine patient care costs do not include:

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

If your plan includes In-Network providers, clinical trials conducted by non-Participating Providers will be covered at the In-Network benefit level if:
• there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
• the clinical trial is conducted outside the individual’s state of residence.

Genetic Testing
Charges made for genetic testing that uses a proven testing method for the identification of genetically linked inheritable disease. Genetic testing is covered only if:
• a person has symptoms or signs of a genetically linked inheritable disease;
• it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically linked inheritable disease when the results will impact clinical outcome; or
• the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

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

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing.

Nutritional Evaluation and Counseling
Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Internal Prosthetic/Medical Appliances
Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Orthognathic Surgery
• orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not correct, provided:
  • the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  • the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
  • the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.
Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

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 under the terms of a Home Health Care plan for the person named in that plan.

If you are a minor or an adult who is dependent upon others for nonskilled 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 nonskilled care needs.

Home Health Care Services are those skilled health care services that can be provided during intermittent visits of two hours or less by Other Health Care Professionals. Home Health Care Services are subject to a maximum of 16 hours in total per day. 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...
Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, 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;
  - 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;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;
    - 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.

Mental Health and Substance Use Disorder Services

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

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

Inpatient Mental Health Services

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

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

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

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

Outpatient Mental Health Services

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

Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency. A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program in accordance with the laws of the appropriate, legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

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

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

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

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

Outpatient Substance Use Disorder Rehabilitation Services
Services provided for the diagnosis and treatment of Substance Use Disorder or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program.

Substance Use Disorder Partial Hospitalization Services are rendered no less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

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

Exclusions
The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
• occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Durable Medical Equipment
• charges made for the purchase or rental of Durable Medical Equipment which is ordered or prescribed by a provider and provided by a vendor approved by Cigna. Coverage for the repair, replacement or duplicate equipment is not covered except when replacement or revision is necessary due to growth or a change in medical condition.

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 Injury or Sickness, are appropriate for use in the home, and are not disposable. Such equipment includes, but is not limited to: crutches, Hospital beds, wheel chairs, respirators, and dialysis machines.

Unless covered in connection with the services described in another section of this certificate, the following are specifically excluded:
• Hygienic or self-help items or equipment;
• Items or equipment that are primarily used for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;
• Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
• Institutional equipment, such as air fluidized beds and diathermy machines;
• Elastic stockings and wigs;
• Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, orthotics, braces and splints;
• Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
• Items which under normal use would constitute a fixture to real property, such as ramps, railings, and grab bars.

Coverage is subject to the maximum shown in The Schedule.

External Prosthetic Appliances and Devices
• charges made for the initial purchase and fitting of external prosthetic devices which are used as replacements or substitutes for missing body parts and are necessary to alleviate or correct Sickness, Injury or congenital defect; including only artificial arms and legs and terminal devices such as hands or hooks. Externtal prosthetics containing biomechanicals or microprocessors are covered as medically necessary when all coverage criteria has been met. Replacement of such prostheses is covered only if needed due to normal anatomical change or reasonable wear and tear which renders item non functioning and non repairable. Cigna does not cover repair or replacement of an external prosthetic device, including an upper limb myoelectric prosthetic device, if the device becomes unusable or nonfunctioning because of individual misuse, abuse or neglect.

Infertility Services
• charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation and diagnostic evaluations.

Infertility is defined as:
• the inability of opposite-sex partners to achieve conception after at least one year of unprotected intercourse;
• the inability of opposite-sex partners to achieve conception after six months of unprotected intercourse, when the female partner trying to conceive is age 35 or older;
• the inability of a woman, with or without an opposite-sex partner, to achieve conception after at least six trials of medically supervised artificial insemination over a one-year period; and
• the inability of a woman, with or without an opposite-sex partner, to achieve conception after at least three trials of medically supervised artificial insemination over a six-month period of time, when the female partner trying to conceive is age 35 or older.

This benefit includes diagnosis and treatment of both male and female infertility.
However, the following are specifically excluded infertility services:

- Artificial Insemination;
- Infertility drugs;
- In vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;
- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Donor charges and services;
- Cryopreservation of donor sperm and eggs; and
- Any experimental, investigational or unproven infertility procedures or therapies.

Coverage is provided when Medically Necessary in the most medically appropriate setting to:

- Restore function (called “rehabilitative”):
  - To restore function that has been impaired or lost.
  - To reduce pain as a result of Illness, Injury, or loss of a body part.
- Improve, adapt or attain function (sometimes called “habilitative”):
  - To improve, adapt or attain function that has been impaired or was never achieved as a result of congenital abnormality (birth defect).
  - To improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions. Includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.

Coverage is provided as part of a program of treatment when the following criteria are met:

- The individual’s condition has the potential to improve or is improving in response to therapy, and maximum improvement is yet to be attained.
- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The therapy is provided by, or under the direct supervision of, a licensed health care professional acting within the scope of the license.
- The therapy is Medically Necessary and medically appropriate for the diagnosed condition.

Therapy services that are not covered include:

- sensory integration therapy;
- treatment of dyslexia;
- maintenance or preventive treatment provided to prevent recurrence or to maintain the patient’s current status;
- charges for Chiropractic Care not provided in an office setting; or
- vitamin therapy.

Coverage is administered according to the following:

- Multiple therapy services provided on the same day constitute one day of service for each therapy type.

A separate Copayment applies to the services provided by each provider for each therapy type per day.
Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and prosthetics, limited to the lowest cost alternative available that meets prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

Transplant Services

- charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States. This coverage is subject to the following conditions and limitations.

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

All Transplant services, other than cornea, must be received at a Cigna LIFESOURCE Transplant Network® facility. Cornea transplants are payable when received from Participating Provider facilities other than Cigna LIFESOURCE Transplant Network® facilities. Transplant services received at any other facilities are not covered.

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

Transplant Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations.

Transplant travel benefits are not available for cornea transplants. Benefits for transportation and lodging are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); and lodging while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age. The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available when the covered person is a donor.
Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that are administered in an Inpatient setting, Outpatient setting, Physician’s office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product’s FDA labeling.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug Product first.

The Cigna Business Decision Team determines whether utilization management requirements or other coverage conditions should apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee’s evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical’s cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. When considering a Medical Pharmaceutical for a coverage status, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

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 Cigna only to a person who:

- resides in a state that requires offering a conversion policy,
- is Entitled to Convert, and
- applies in writing and pays the first premium for the Converted Policy to Cigna 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 but only if:

- you are not eligible for other individual insurance coverage on a guaranteed issue basis.
- 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.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

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 who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose
insurance under this plan ceases due to divorce, annulment of marriage or your death;

- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for other individual insurance coverage on a guaranteed issue basis, is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

**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 Cigna's underwriting standards for individual policies.

Similar Benefits are: 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; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

**Converted Policy**

If you reside in a state that requires the offering of a conversion policy, the Converted Policy will be one of Cigna's current conversion policy offerings available in the state where you reside, as determined based upon Cigna's rules.

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 Entitled to Convert, 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: class of risk and age; and benefits.

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 (if any) 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
**Prescription Drug Benefits**

**The Schedule**

**For You and Your Dependents**

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion includes any applicable Copayment, Deductible and/or Coinsurance. Your Deductible or Coinsurance payment, if any, will be based on the Drug Charge for the Prescription Drug or Related Supply.

**Coinsurance**

The term Coinsurance means the percentage of Charges for covered Prescription Drugs and Related Supplies that you or your Dependent are required to pay under this plan.

**Drug Charges**

The term Charges means the amount charged by Cigna to the plan when the Pharmacy is a Participating Pharmacy, and it means the actual billed charges when the Pharmacy is a non-Participating Pharmacy. Cigna may pay a Participating Pharmacy a different amount for a Prescription Drug or Related Supply than the plan pays to Cigna. You are not entitled to the difference between the rate Cigna charges to the plan and the rate Cigna pays to the Pharmacy for a Prescription Drug or Related Supply.

**Copayments**

Copayment Amounts are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies.

**Out-of-Pocket Expenses**

Out-of-Pocket Expenses are Covered Expenses incurred at a Pharmacy for Prescription Drugs and Related Supplies for which no payment is provided because of the Coinsurance factor and any Copayment Amounts or Deductibles. When the Out-of-Pocket maximum shown in The Schedule is reached, benefits are payable at 100%.

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>NETWORK PHARMACY</th>
<th>NON-NETWORK PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,850 per person</td>
<td>$3,850 per person</td>
</tr>
<tr>
<td>Family</td>
<td>$7,700 per family</td>
<td>$7,700 per family</td>
</tr>
</tbody>
</table>

**Maintenance Drug Products**

Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Pharmacy or home delivery Pharmacy.

Certain Preventive Care Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required.
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>NETWORK PHARMACY</th>
<th>NON-NETWORK PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drug Products at Retail Pharmacies</td>
<td>The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy</td>
<td>The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy</td>
</tr>
</tbody>
</table>

Prescription smoking cessation drugs are covered at a $0 copay.
OTC smoking cessation drugs are covered at $0 with a valid prescription.

<table>
<thead>
<tr>
<th>Tier 1</th>
<th>Generic Drugs on the Prescription Drug List</th>
<th>No charge after $20 Copay</th>
<th>30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 2</td>
<td>Brand Drugs designated as preferred on the Prescription Drug List with no Generic equivalent</td>
<td>No charge after $50 Copay</td>
<td>30%</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List</td>
<td>No charge after $70 Copay</td>
<td>30%</td>
</tr>
</tbody>
</table>

| Prescription Drug Products at Retail Designated Pharmacies | The amount you pay for up to a consecutive 90-day supply at a Designated Pharmacy | The amount you pay for up to a consecutive 90-day supply at a non-Designated Pharmacy |

Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill.

Note: In this context, a retail Designated Pharmacy is a retail Network Pharmacy that has contracted with Cigna for dispensing of covered Prescription Drug Products, including Maintenance Drug Products, in 90-day supplies per Prescription Order or Refill.

Prescription smoking cessation drugs are covered at a $0 copay.
OTC smoking cessation drugs are covered at $0 with a valid prescription.100%

<table>
<thead>
<tr>
<th>Tier 1</th>
<th>Generic Drugs on the Prescription Drug List</th>
<th>No charge after $40 Copay</th>
<th>30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 2</td>
<td>Brand Drugs designated as preferred on the Prescription Drug List with no Generic equivalent</td>
<td>No charge after $100 Copay</td>
<td>30%</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List</td>
<td>No charge after $140 Copay</td>
<td>30%</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>NETWORK PHARMACY</td>
<td>NON-NETWORK PHARMACY</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>Prescription Drug Products at Home Delivery Pharmacies</td>
<td>The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy</td>
<td>The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy</td>
<td></td>
</tr>
</tbody>
</table>

Prescription smoking cessation drugs are covered at a $0 copay. OTC smoking cessation drugs are covered at $0 with a valid prescription.

**Tier 1**
- Generic Drugs on the Prescription Drug List
  - No charge after $40 Copay
  - In-network coverage only

**Tier 2**
- Brand Drugs designated as preferred on the Prescription Drug List with no Generic equivalent
  - No charge after $100 Copay
  - In-network coverage only

**Tier 3**
- Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List
  - No charge after $140 Copay
  - In-network coverage only
Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 90 day supply at a home delivery Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.
- if two or more prescriptions or refills are dispensed at the same time a Copayment must be paid for each prescription order or refill.

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

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

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

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

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment Amount or Coinsurance shown in the Schedule, after you have satisfied your Prescription Drug Deductible, if applicable. Please refer to the Schedule for any required Copayment Amounts, Coinsurance, Deductibles or Maximums if applicable.

1.  
2.  

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to Cigna to request a prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.
When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for your convenience, a Copayment Amount will apply to each Prescription Drug.

In no event will the Copayment for the Prescription Drug or Related Supply exceed the Drug Charge, or the Pharmacy’s Usual and Customary (U&C) charge. Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers regardless of the customer’s payment source.

Exclusions

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law unless state or federal law requires coverage of such drugs;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in the standard reference compendia (AHFS or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in peer-reviewed English-language bio-medical journals;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- any fertility drug;
- prescription vitamins (other than prenatal vitamins), dietary supplements and fluoride products;
- diet pills or appetite suppressants (anorectics);
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue;
- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product;
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time;
any drugs that are experimental or investigational as described under the Medical “Exclusions” section of your certificate. Other limitations are shown in the Medical “Exclusions” section of your certificate.

Reimbursement/Filing a Claim
When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Copayment Amount, Coinsurance or Deductible shown in the Schedule at the time of purchase. You do not need to file a claim form.

If you or your Dependents purchase your Prescription Drugs or Related Supplies through a non-Participating Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a home delivery Participating Pharmacy, see your home delivery drug introductory kit for details, or contact member services for assistance.

See your Employer's Benefit Plan Administrator to obtain the appropriate claim form.

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in The Schedule. Payment for the following is specifically excluded from this plan:

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, undeclared, riot or insurrection.
- charges which you are not obligated 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 plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna’s express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” sections of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified myCigna.com
clinical trials as provided in the “Clinical Trials” sections of this plan.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

• cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.

• the following services are excluded from coverage regardless of clinical indications: acupressure; dance therapy; movement therapy; applied kinesiology; rolling; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

• Rhinoplasty and Blepharoplasty and Stereotactic Radio surgery (Cyber Knife) are covered only when Medically Necessary.

• 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 other than cleft related conditions. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.

• for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the Body Mass Index (BMI) classifications of the National Heart, Lung, and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:
  • medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and
  • weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

• unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.

• court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.

• for treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction, anorgasmy, and premature ejaculation.

• medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.

• non-medical counseling and/or ancillary services, including but not limited to Custodial Services, educational services, vocational counseling, training and, rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.

• therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

• 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 “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.

• private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.

• 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 an Injury or Sickness.

• for replacement of external prostheses due to loss, theft or destruction.

• artificial aids, including but not limited to corrective orthopedic shoes, arch supports or orthotics, elastic stockings, garter belts, corsets, dentures and wigs.

• hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
• aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
• eyelash lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
• routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
• all non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
• routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
• membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
• genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
• dental implants for any condition.
• fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
• blood administration for the purpose of general improvement in physical condition.
• cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
• cosmetics, dietary supplements and health and beauty aids.
• all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
• medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a non-Participating provider.
• medical treatment when payment is denied by a Primary Plan because treatment was received from a non-Participating Provider.
• for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
• charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
• massage therapy.

General Limitations
No payment will be made for expenses incurred for you or any one of your Dependents:
• 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 Injury or Sickness.
• 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.
• to the extent that payment is unlawful where the person resides when the expenses are incurred.
• for charges which would not have been made if the person had no insurance.
• to the extent that they are more than Maximum Reimbursable Charges.
• to the extent of the exclusions imposed by any certification requirement shown in this plan.
• expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
• charges made by any covered provider who is a member of your family or your Dependent's family.
• expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.

Coordination of Benefits
This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.
Definitions
For the purposes of this section, the following terms have the meanings set forth below:

Plan
Any of the following that provides benefits or services for medical care or treatment:
- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.
Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan
A Plan that provides medical or dental 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 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 from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense
A necessary, reasonable and customary service or expense, including deductibles, coinsurance or Copayment Amounts, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:
- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period
A calendar year, but does not include any part of a year during which you are not covered under this policy 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.

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:
- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- 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 an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare 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;
- then, the Plan of the parent with custody of the child;
- then, the Plan of the spouse of the parent with custody of the child;
- then, the Plan of the parent not having custody of the child; and
- finally, the Plan of the spouse of the parent not having custody of the child.

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 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.

- 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.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, 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.

**Effect on the Benefits of This Plan**

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

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

As each claim is submitted, Cigna will determine the following:
- Cigna's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

**Recovery of Excess Benefits**

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have 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 made by any insurance company, healthcare Plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

**Right to Receive and Release Information**

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan will be requested.

**Coordination of Benefits with Medicare**

If you, your spouse, or your Dependent are covered under this Plan and qualify for Medicare, federal law determines which Plan is the primary payer and which is the secondary payer. The primary payer always determines covered benefits first, without considering what any other coverage will pay. The secondary payer determines its coverage only after the Primary Plan has completed its determination.
When Medicare is the Primary Payer
Medicare will be the primary payer and this Plan will be the secondary payer, even if you don’t elect to enroll in Medicare or you receive services from a provider who does not accept Medicare payments, in the following situations:

- **COBRA or State Continuation**: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to COBRA or state continuation of coverage.
- **Retirement or Termination of Employment**: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to your retirement or termination of employment.
- **Disability**: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has fewer than 100 employees.
- **Age**: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has fewer than 20 employees.
- **End Stage Renal Disease (ESRD)**: You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan will be the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

When This Plan is the Primary Payer
This Plan will be the primary payer and Medicare will be the secondary payer in the following situations:

- **Disability**: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has 100 or more employees.
- **Age**: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has 20 or more employees.
- **End Stage Renal Disease (ESRD)**: You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan is the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

**Domestic Partners**
Under federal law, when Medicare coverage is due to age, Medicare is always the primary payer and this Plan is the secondary payer for a person covered under this Plan as a Domestic Partner. However, when Medicare coverage is due to disability, the Disability payer explanations above will apply.

**IMPORTANT**: If you, your spouse, or your Dependent do not elect to enroll in Medicare Parts A and/or B when first eligible, or you receive services from a provider who does not accept Medicare payments, this Plan will calculate payment based on what should have been paid by Medicare as the primary payer if the person had been enrolled or had received services from a provider who accepts Medicare payments. A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective.

**Failure to Enroll in Medicare**
If you, your spouse, or your Dependent do not enroll in Medicare Parts A and/or B during the person’s initial Medicare enrollment period, or the person opts out of coverage, the person may be subject to Medicare late enrollment penalties, which can cause a delay in coverage and result in higher Medicare premiums when the person does enroll. It can also result in a reduction in coverage under Medicare Parts A and B. If you are planning to retire or terminate employment and you will be eligible for COBRA, state Continuation, or retiree coverage under this Plan, you should enroll in Medicare before you terminate employment to avoid penalties and to receive the maximum coverage under Medicare. Please consult Medicare or the Social Security Administration for more information.

**Assistance with Medicare Questions**
For more information on Medicare’s rules and regulations, contact Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. You may also contact the Social Security Administration toll-free at 1-800-772-1213, at www.ssa.gov, or call your local Social Security Administration office.

**Expenses For Which A Third Party May Be Responsible**
This plan does not cover:

- Expenses incurred by you or your Dependent; (hereinafter individually and collectively referred to as a "Participant," ) for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid),
or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault or similar coverage.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan’s subrogation rights.

- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;

- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;

- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan’s right to recover shall apply to decedents’, minors’, and incompetent or disabled persons’ settlements or recoveries.

- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.

- The plan’s right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called “Made-Whole Doctrine”, “Rimes Doctrine”, or any other such doctrine purporting to defeat the plan’s recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan’s rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan’s recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called “Fund Doctrine”, “Common Fund Doctrine”, or “Attorney’s Fund Doctrine”.

- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.

- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney’s fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

- Any reference to state law in any other provision of this plan shall not be applicable to this provision. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Payment of Benefits

Assignment and Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make
a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

You may, however, authorize Cigna to pay any healthcare benefits under this policy to a Participating or Non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or Non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider’s responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Expenses directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or Non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a Non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the Non-Participating Provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna, 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, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

**Recovery of Overpayment**

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

**Calculation of Covered Expenses**

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

**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 last day of the calendar month in which 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 as determined by your Employer.

**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, your insurance will not continue past the date your Employer cancels your insurance.

**Retirement**

If your Active Service ends because you retire, you may continue to be insured within the provisions of your Employer’s policies and Florida law. For your insurance to
continue as a retiree, you will have to pay all or part of the premium, as determined by your Employer.

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.

**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.

**Rescissions**

Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact. Coverage will be rescinded in the case of fraud or intentional misrepresentation of a material fact. If coverage is rescinded, 30 days advance notice to the enrollee is required.

Termination of coverage is not considered "rescission" and, therefore, not subject to the 30 day advance notice if:
- it is not retroactive
- it is due to late or non-payment of premiums/contributions toward the cost of coverage
- if it is initiated by the employee

Coverage for you or any one of your dependents may also be terminated due to administrative error, back to the paid through date. In case of administrative error the coverage termination date can also be retroactive, as long as you consent and applicable premiums are refunded.

**Medical Benefits Extension Upon Policy Cancellation**

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury, Sickness or pregnancy, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury, Sickness or pregnancy. 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 a succeeding carrier agrees to provide coverage without limitation for the disabling condition;
- the date you are no longer Totally Disabled;
- 12 months from the date the policy is canceled; or
- for pregnancy, until delivery.

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

Notice of Provider Directory/Networks
Notice Regarding Provider Directories and Provider Networks
A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

Notice Regarding Pharmacy Directories and Pharmacy Networks
A list of network pharmacies is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of pharmacies affiliated or contracted with Cigna or an organization contracting on its behalf.

Qualified Medical Child Support Order (QMCSO)
Eligibility for Coverage Under a QMCSO
If a Qualified Medical Child Support Order (QMCSO) 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 QMCSO being issued.

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

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

The QMCSO 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 that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits
Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child’s custodial parent or legal guardian, shall be made to 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.

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

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.

- **Loss of eligibility for State Medicaid or Children’s Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.

- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan’s network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.

- **Termination of Employer contributions (excluding continuation coverage).** If a current or former Employer ceases all contributions toward the Employee’s or Dependent’s other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).

- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the Employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan’s service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an Employer’s limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

- **Eligibility for employment assistance under State Medicaid or Children’s Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.
Effect of Section 125 Tax Regulations on This Plan

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

A. Coverage elections

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

- if you meet Special Enrollment criteria and enroll as described in the Special Enrollment section; or
- if your Employer agrees, and you meet the criteria shown in the following Sections B through F.

B. Change of status

A change in status is defined as:

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

Any changes in coverage must correspond directly to the change in status.

C. Court order

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

D. Medicare or Medicaid eligibility/entitlement

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

E. Change in cost of coverage

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

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

F. Changes in coverage of spouse or Dependent under another employer’s plan

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

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 “Exception for Newborns” section of this document 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.

Coverage for Maternity Hospital Stay

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending...
provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Women’s Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and 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, as amended, where applicable:

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, as amended; 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.

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, as amended, 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 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, as amended.

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 an Employee’s military leave 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 & Dismemberment coverage you may have.

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 Dependents as follows:

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

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
• the date the policy cancels.
Your Employer may charge you and your Dependents up to 102% of the total premium.

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

Reinstatement of Benefits (applicable to all coverages)
If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and 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 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.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

Claim Determination Procedures
The following complies with federal law. Provisions of applicable 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 a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. The booklet describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described below, in the booklet, and in your provider’s network participation documents as applicable.

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination.

Appeal procedures are described in the booklet, in your provider’s network participation documents as applicable, and in the determination notices.

Note: An oral statement made to you by a representative of Cigna or its designee that indicates, for example, a particular service is a Covered Expense, is authorized for coverage by the plan, or that you are eligible for coverage is not a guarantee that you will receive benefits for services under this plan. Cigna will make a benefit determination after a claim is received from you or your authorized representative, and the benefit determination will be based on, your eligibility as of the date services were rendered to you and the terms and conditions of the plan in effect as of the date services were rendered to you.

Preservice Determinations
When you or your representative requests a required prior authorization, Cigna 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 Cigna’s control, Cigna 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 Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna 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 seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna will defer to the determination of the treating health care professional regarding whether an expedited determination is necessary. Cigna 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, Cigna 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 Cigna within 48 hours after receiving the notice. Cigna 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 attempts to request a preservice determination, but fails to follow Cigna’s procedures for requesting a required preservice determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 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 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 coverage 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, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

**Postservice Determinations**

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna 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 Cigna’s control, Cigna 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.

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 Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna 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: information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan’s review procedures and the time limits applicable following an adverse benefit determination on appeal, (if applicable); 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; a description of any available internal appeal and/or external review process(es); information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

**Appointment of Authorized Representative**

You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However, Cigna may require you to designate your authorized representative in writing using a form approved by Cigna. At all times, the appointment of an authorized representative is revocable by you. To ensure that a prior appointment remains valid, Cigna may require you to re-appoint your authorized representative, from time to time.

Cigna reserves the right to refuse to honor the appointment of a representative if Cigna reasonably determines that:

- the signature on an authorized representative form may not be yours, or
- the authorized representative may not have disclosed to you all of the relevant facts and circumstances relating to the overpayment or underpayment of any claim, including, for example, that the billing practices of the provider of medical services may have jeopardized your coverage through the waiver of the cost-sharing amounts that you are required to pay under your plan.

If your designation of an authorized representative is revoked, or Cigna does not honor your designation, you may appoint a new authorized representative at any time, in writing, using a form approved by Cigna.

**Medical - 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.

“Physician Reviewers” are licensed Physicians depending on the care, service or treatment under review.

We want you to be completely satisfied with the care and services 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, contractual benefits, or a rescission of coverage, you may 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 may 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 may start the appeals procedure.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal of an adverse benefit determination, you must submit a request for an appeal in writing to Cigna 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 Cigna to register your appeal by telephone. Call or write us at the toll-free number 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 preservice 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, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your health care provider would cause you severe pain which cannot be managed without the requested services.

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

Cigna’s Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna 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.

Requests for a level-two appeal regarding the Medical Necessity or clinical appropriateness of your issue will be conducted by a Committee, which consists of one or more people not previously involved in the prior decision. The Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by Cigna’s Physician reviewer. You may present your situation to the Committee in person or by conference call.

For required preservice and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for post service 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.

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

You will be notified in writing of the Committee’s decision within 5 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, 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 your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna’s Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

**Independent Review Procedure**

If you are not fully satisfied with the decision of Cigna’s level-two appeal review and the appeal involves medical judgment or a rescission of coverage, 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 request an appeal to an Independent Review Organization 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. Cigna will abide by the decision of the Independent Review Organization.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna’s level-two appeal review denial. Cigna will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna’s Physician reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the review shall be completed within 72 hours.

**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: information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific plan provisions on which the determination is based; 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; a statement describing any voluntary appeal procedures offered by the plan; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

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 relied upon in making the benefit determination; 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; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or 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**

In most instances, you may not initiate a legal action against Cigna 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.

**COBRA Continuation Rights Under Federal Law**

**For You and Your Dependents**

**What is COBRA Continuation Coverage?**

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a “qualifying event” that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan’s coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.
When is COBRA Continuation Available?
For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?
Only a “qualified beneficiary” (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals’ coverage will terminate when your COBRA continuation coverage terminates. The sections titled “Secondary Qualifying Events” and “Medicare Extension For Your Dependents” are not applicable to these individuals.

Secondary Qualifying Events
If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension
If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for “Termination of COBRA Continuation” listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents
When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation
COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer’s policy with Cigna;
• after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
• after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
• any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer’s Service Area or Elimination of a Service Area
If you and/or your Dependents move out of the Employer’s service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer’s service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer’s Notification Requirements
Your Employer is required to provide you and/or your Dependents with the following notices:
• An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse’s) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
• A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  • if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  • if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or

• in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage
The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?
Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any “Conversion Privilege” shown in your certificate.
**When and How to Pay COBRA Premiums**

*First payment for COBRA continuation*

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

*Subsequent payments*

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

*Grace periods for subsequent payments*

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

**You Must Give Notice of Certain Qualifying Events**

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

**Newly Acquired Dependents**

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

**COBRA Continuation for Retirees Following Employer’s Bankruptcy**

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

**Interaction With Other Continuation Benefits**

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

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**Discretionary Authority**

The Employer delegates to Cigna 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 Employer also delegates to Cigna the discretionary authority to perform a full and fair review of each claim denial which has been appealed by the claimant or his duly authorized representative.

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 Cigna for a different amount.

Custodial Services
Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition.

This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:
• Services related to watching or protecting a person;
• Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self administered, and
• Services not required to be performed by trained or skilled medical or paramedical personnel.

Dependent
Dependents are:
• your lawful spouse; or
• your Domestic Partner; and
• any child of yours who is
  • less than 26 years old.
  • from 26 years until the end of the calendar year in which the child reaches the age of 30, provided the child is unmarried and does not have a dependent of his own, is a Florida state resident or a full-time or part-time student, and is not covered under a plan of their own or entitled to benefits under Title XVIII of the Social Security Act. CIGNA may require such proof at least once each year until the end of the calendar year in which he attains age 30; and
  • who is 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

Proof of the child's condition and dependence may be required to be submitted to the plan as a condition of coverage after the date the child ceases to qualify above. However, if a claim is denied, proof must be submitted by the Employee that the child is and has continued to be mentally or physically handicapped.

Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to
time, but not more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. A child also includes a foster child or a child placed in your custody by a court order from the date of placement in the home, or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent. Coverage is not required if the adopted or foster child is ultimately not placed in your home. It also includes:

- a stepchild;
- a child born to an insured Dependent child of yours until such child is 18 months old.

Benefits for a Dependent child or student will continue until the last day of the calendar year in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent spouse. A child under age 26 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee.

No one may be considered as a Dependent of more than one Employee.

**Domestic Partner**

- Your qualified Domestic Partner may be eligible for coverage under the plan if he or she meets your employer’s defined criteria, which requires that:
  - Each party is at least 18 years old and is competent to enter into a contract.
  - Neither party is married, or is a partner to another domestic partnership relationship.

Each party is the sole Domestic Partner of the other person

- Both parties consent to the domestic partnership relationship without force, duress or fraud.
- Both parties agree to be jointly responsible for each other’s basic food, shelter, common necessities of life and welfare.
- Neither party has been a member of another domestic partnership for the past year.
- Each party shares his or her primary residence with the other party.
- Each party considers himself/herself to be a member of the immediate family of the other partner.

The section of this certificate entitled "COBRA Continuation Rights By Federal Law" will not apply to your Domestic Partner and

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a County that provides for such registration.

**Designated Pharmacy**

A Participating Pharmacy that has entered into an agreement with Cigna, or with an entity contracting on Cigna’s behalf, to provide Prescription Drugs and Related Supplies or services, including, without limitation, specific Prescription Drugs and Related Supplies, to plan enrollees on a preferred or exclusive basis. For example, a Designated Pharmacy may provide enrollees with an extended days’ supply of Prescription Drugs and Related Supplies. The fact that a Pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

**Emergency Medical Condition**

Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.
Emergency Services
Emergency services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Employee
The term Employee means a full-time, classified as permanent employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

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

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 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.

Home Health Care Agency
The term Home Health Care Agency means a Hospital or a nonprofit 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 Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or 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 Cigna; 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: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and 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 Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance Use Disorder or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

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;
- receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

**In-Network/Out-of-Network**

The term In-Network refers to healthcare services or items provided by your Primary Care Physician or services/items provided by another Participating Provider and authorized by your Primary Care Physician or the Review Organization. Authorization by your Primary Care Physician or the Review Organization is not required in the case of Mental Health and Substance Abuse treatment, other than Hospital Confinement solely for detoxification.

The term Out-of-Network refers to care which does not qualify as In-Network. Emergency Care which meets the definition of Emergency Services and is authorized as such by either the Primary Care Physician or the Review Organization is considered In-Network. (For details, refer to the Emergency Services and Urgent Care coverage section.)
Injury
The term Injury means an accidental bodily injury.

Maximum Reimbursable Charge - Medical
The Maximum Reimbursable Charge for covered services is determined based on the lesser of:
- the provider’s normal charge for a similar service or supply;
- or
- a policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge or for help determining the Maximum Reimbursable Charge for a specified service is available upon request by calling the toll-free number shown on your ID card.

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.

Medical Pharmaceutical
An FDA-approved prescription pharmaceutical product, including a Specialty Prescription Drug Product, typically required to be administered in connection with a covered service by a Physician or other health care provider within the scope of the provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Physician oversight but may be self-administered under certain conditions specified in the product’s FDA labeling. This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

Medically Necessary/Medical Necessity
Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:
- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

Medicare
The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

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.

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."

Ophthalmologist
The term Ophthalmologist means a person practicing ophthalmology within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

Optician
The term Optician means a fabricator and dispenser of eyeglasses and/or contact lenses. An optician fills prescriptions for glasses and other optical aids as specified by optometrists or ophthalmologists. The state in which an optician practices may or may not require licensure for rendering of these services.

Optometrist
The term Optometrist means a person practicing optometry within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

Other Health Care Facility/Other Health Professional
The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants and Surgical First Assistants.

Participating Pharmacy
The term Participating Pharmacy means a retail Pharmacy with which Cigna has contracted to provide prescription services to insureds, or a designated home delivery Pharmacy with which Cigna has contracted to provide home delivery prescription services to insureds. A home delivery Pharmacy is a Pharmacy that provides Prescription Drugs through mail order.

Participating Provider
The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

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

Pharmacy
The term Pharmacy means a retail Pharmacy, or a home delivery Pharmacy.
**Pharmacy & Therapeutics (P & T) Committee**

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

**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.

**Prescription Drug**

Prescription Drug means; a drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

**Prescription Order**

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

**Primary Care Physician**

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and who has been selected by you, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents. If you or your dependent is a covered Florida resident using the Florida Managed Care Network, the term Primary Care Physician will also include a Physician who qualifies as a Participating Provider in Obstetrics/Gynecology.

**Provider Organization**

The term Provider Organization refers to a network of Participating Providers.

- **Prescription Drug List**

  Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.
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; and any psychotherapist while he is providing care authorized by the Provider Organization if he is state licensed or nationally certified by his professional discipline and performing a service for which benefits are provided under this plan when performed by a Psychologist.

Sickness – For Medical Insurance
The term Sickness means a physical or mental 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: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

Specialist
The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

Stabilize
Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.
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 are not Emergency Services, but which are determined by Cigna, 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 were 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 the insured should not travel due to any medical condition.