

**Newport-Mesa Unified School
District**

OPEN ACCESS PLUS MEDICAL
BENEFITS

EFFECTIVE DATE: October 1, 2015

CN021
3214052

This document printed in September, 2015 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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*Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152*

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Newport-Mesa Unified School District

GROUP POLICY(S) — COVERAGE

3214052 - OAP OPEN ACCESS PLUS MEDICAL BENEFITS

EFFECTIVE DATE: October 1, 2015

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.


Anna Krishdul, Corporate Secretary

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

When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

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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 an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

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.

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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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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 allows 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. 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.

HC-NOT5

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Important Information

Mental Health Parity and Addiction Equity Act

The Certificate is amended as stated below:

In the event of a conflict between the provisions of your plan documents and the provisions of this notice, the provisions that provide the better benefit shall apply.

The Schedule and Mental Health and Substance Abuse Covered Expenses:

Partial Hospitalization charges for Mental Health and Substance Abuse will be paid at the Outpatient level. Covered Expenses are changed as follows:

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

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 are 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, or for Partial Hospitalization sessions, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which 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.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Inpatient Substance Abuse 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 Abuse Services include Residential Treatment services.

Substance Abuse 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 Abuse conditions.

Substance Abuse Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; 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 Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse 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 Abuse Intensive Outpatient Therapy Program and for Partial Hospitalization sessions.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. 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 Abuse 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.

Mental Health and Substance Abuse Exclusions:

The following exclusion is hereby deleted and no longer applies:

- 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.

Terms within the agreement:

The term “mental retardation” within your Certificate is hereby changed to “intellectual disabilities”.

Visit Limits:

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

HC-NOT69

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Accessing Health Care

To contact the Department of Insurance, for complaints regarding your ability to access health care in a timely manner, write or call:

Consumer Affairs Division
California Department of Insurance
Ronald Reagan Building
300 South Spring Street
Los Angeles, CA 90013

Calling within California: 1-800-927-4357

Los Angeles Area and Outside California: 1-213-897-8921

The Department of Insurance should be contacted only after discussions with the insurer have failed to produce a satisfactory resolution to the problem.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

Participating Providers

Copayment, Deductible, and Coinsurance options reflect the amount the covered person will pay for in-network and out-of-network benefits. In-network benefits require use of Participating Providers or facilities in the Service Area. Cigna recommends use of Participating Providers and facilities, as member out-of-pocket costs could be lower than when using non-Participating Providers.

Service Area

The term Service Area means the area in which Cigna has a Participating Provider network. Cigna's national network of Participating Providers is within the United States. Cigna's toll-free care line personnel can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may obtain a listing of Participating Providers by calling the number on your I.D. card. A listing of Participating Providers can also be found at www.Cigna.com.

Away From Home Care

If you or your Dependents need medical care while away from home, you may have access to a national network of Participating Providers through Cigna's Away-From-Home Care feature. Call the number on your I.D. card for the names of Participating Providers in other network areas.

Emergency Services

Benefits for services and supplies received outside the Service Area are covered only for medical emergencies and other urgent situations where treatment could not have been reasonably delayed until the insured person was able to return to the United States.

To contact the Department of Insurance, write or call:

Consumer Affairs Division
California Department of Insurance
Ronald Reagan Building
300 South Spring Street
Los Angeles, CA 90013

Calling within California: 1-800-927-4357

Los Angeles Area and Outside California: 1-213-897-8921

The Department of Insurance should be contacted only after discussions with the insurer have failed to produce a satisfactory resolution to the problem.

Your Rights Under HIPAA If You Lose Group Coverage

Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. California law provides similar and additional protections. If you lose group health insurance coverage and meet certain criteria, you are entitled to purchase individual health coverage (nongroup) from any health plan that sells individual coverage for hospital, medical or surgical benefits. Every health plan that sells individual health coverage for these benefits must offer individual coverage to an eligible person under HIPAA. The health plan cannot reject your application if: you are an eligible person under HIPAA; you agree to pay the required premiums; and you live or work inside the plan's service area. To be considered an eligible person under HIPAA you must meet the following requirements:

- you have 18 or more months of creditable coverage without a break of 63 days or more between any of the periods of creditable coverage or since your most recent coverage was terminated;
- your most recent creditable coverage was a group, government or church plan that provided hospital, medical or surgical benefits. (COBRA and Cal-COBRA are considered group coverage);
- you were not terminated from your most recent creditable coverage due to nonpayment of premiums or fraud;
- you are not eligible for coverage under a group health plan, Medicare, or Medicaid (Medi-Cal);
- you have no other health insurance coverage; and
- you have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA.

There are important choices you need to make in a very short time frame regarding the options available to you following termination of your group health care coverage. You should read carefully all available information regarding HIPAA coverage so you can understand fully the special protections of HIPAA coverage and make an informed comparison and choice regarding available coverage. For more information, please call the number on your ID card.

If you believe your HIPAA rights have been violated, you should contact the CA Dept of Insurance or visit the Department's web site.

Important Notices

Important Information About Free Language Assistance

No Cost Language Services for members who live in California and members who live outside of California who are covered under a policy issued in California. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number



listed on your ID card or 1-800-244-6224 for Cigna medical/dental or 1-866-421-8629 for Cigna Behavioral Health mental health/substance abuse. For more help call the CA Dept. of Insurance at 1-800-927-4357. **English**

Servicios de idioma sin costo para miembros que viven en California y para miembros que viven fuera de California y que están cubiertos por una póliza emitida en California. Puede obtener un intérprete. Puede hacer que le lean los documentos en español y que le envíen algunos de ellos en ese idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o a 1-800-244-6224 para servicios médicos/dentales de Cigna o al 1-866-421-8629 para servicios de salud mental/farmacodependencia de Cigna Behavioral Health. Para obtener ayuda adicional, llame al Departamento de Seguros de CA al 1-800-927-4357. **Spanish**

居住在加州境內的會員和居住在加州境外但受到加州境內核發保單承保的會員可取得免費之語言服務。您可取得口譯員服務。我們可以用中文將文件讀給您聽，並將部分備有中文版的文件寄送給您。欲取得協助，請撥打您會員卡上所列示的電話號碼，或致電 1-800-244-6224 與 Cigna 醫療 / 牙科聯絡，或撥打 1-866-421-8629 聯繫 Cigna Behavioral Health 精神健康 / 物質濫用。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。 **Chinese**

خدمات لغوية بدون تكلفة للأعضاء المقيمين في ولاية كاليفورنيا والأعضاء المقيمين خارج ولاية كاليفورنيا المشمولين في تغطية بوليصة التأمين الصادرة في ولاية كاليفورنيا. يمكنكم الاستعانة بمترجم وطلب قراءة الوثائق باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك على الرقم 1-800-244-6224 لخدمات Cigna الطبية وصحة الأسنان أو على الرقم 1-866-421-8629 لخدمات Cigna للصحة السلوكية والنفسية وإساءة استعمال المواد المخدرة. للحصول على المزيد من المساعدة، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. **Arabic**

무료 통역 서비스. 귀하는 한국어 통역 서비스 및 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 기재된 안내번호, 혹은 Cigna 의료/치과 치료 안내번호 (1-800-244-6224번), 혹은 Cigna Behavioral Health 정신건강/약물남용 안내번호(1-866-421-8629번)로 연락해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내전화 1-800-927-4357번으로 연락해 주십시오. **Korean**

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng isang interpreter o tagasalin at mapababasa mo ang mga dokumento sa Tagalog. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o kaya sa 1-800-244-6224 para sa Cigna medical/dental o kaya sa 1-866-421-8629 para sa Cigna Behavioral Health mental health/substance abuse. Para sa karagdagang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357. **Tagalog**

Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên giúp đỡ và được đọc giúp tài liệu bằng tiếng Việt. Để được giúp đỡ, xin gọi chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc gọi số 1-800-244-6224 nếu liên quan tới bảo hiểm y tế/nha khoa của Cigna hoặc số 1-866-421-8629 nếu liên quan tới dịch vụ sức khỏe tâm thần/cai nghiện rượu/ma túy của Cigna Behavioral Health. Để được giúp đỡ thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. **Vietnamese.**

ការបកប្រែភាសាដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានការបកប្រែ និងឱ្យអានឯកសារឱ្យអ្នកស្តាប់ ជាភាសាខ្មែរបាន ។ សំរាប់ព័ន្ធយូម៉ែរស្តូមស្តូមកម្រើង តាម លេខដែលមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ឬលេខ 1-800-244-6224 សំរាប់ខាងពេទ្យ/ផ្ទះ Cigna ឬ 1-866-421-8629 សំរាប់ខាងការបម្រើសុខភាព អារម្មណ៍ Cigna /ការរំលោភសារធាតុញ្ញាត ។ សំរាប់ព័ន្ធយូម៉ែរស្តូមស្តូមកម្រើង តាមលេខ 1-800-927-4357 ។ **Khmer**

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਬਾਰੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ, ਜਾਂ 1-800-244-6224 ਨੰਬਰ ਤੇ Cigna ਮੈਡੀਕਲ/ਡੈਂਟਲ ਲਈ, ਜਾਂ 1-866-421-8629 ਨੰਬਰ ਤੇ Cigna ਵਿਹਾਰਕ ਸਿਹਤ, ਮਾਨਸਿਕ ਸਿਹਤ ਅਤੇ /ਜਾਂ ਪਦਾਰਥਾਂ ਦੀ ਦੁਰਵਰਤੋਂ ਲਈ ਫੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੋਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫੋਨ ਕਰੋ। **Punjabi**

خدمات مجاني مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شده و بگویند مدارک به زبان خودتان برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است تماس بگیرید و یا به شماره 1-800-244-6224 برای طرح پزشکی/دندانپزشکی Cigna و یا به شماره 1-866-421-8629 برای برنامه بهداشت روانی/اسوء استفاده از مواد مخدر طرح سلامت رفتاری Cigna تلفن کنید. برای دریافت کمک بیشتر به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. **Persian**

無料の言語サービス。通訳がご利用になれば、書類を日本語でお読みします。サービスをご希望の方は、IDカード記載の番号までご連絡ください。また、Cigna 医療・歯科サービス担当、1-800-244-6224、或いは、Cigna 行動医療精神衛生/薬物乱用治療担当、1-866-421-8629にもお問い合わせいただけます。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。 **Japanese.**

Бесплатные услуги перевода. Вы можете воспользоваться услугами устного переводчика, который прочитает вам документы на русском языке. Для получения помощи позвоните нам по номеру телефона, указанному в вашей карточке-удостоверении, либо по телефону 1-800-244-6224 по вопросам медицинского/стоматологического обслуживания Cigna или 1-866-421-8629 по вопросам поведенческой медицины в области психиатрической помощи или помощи при злоупотреблении алкоголем и наркотикам Cigna. Для получения дополнительной помощи обращайтесь в Департамент страхования штата Калифорния (California Department of Insurance) по телефону 1-800-927-4357.

Russian

Անվճար Լեզվական Տառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը հայերենով ընթերցել տալ ձեզ համար: Օգնության համար, զանգահարեք մեզ ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-800-244-6224 համարով՝ Cigna-ի բժշկական/ատամնաբուժական ծրագիր, կամ 1-866-421-8629 համարով՝ Cigna-ի Վարվեցողական Առողջության հոգեկան առողջության/թմրանյութի չարաշահման ծրագիր: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆոռնիայի Ապահովագրության Բաժանմունք: **Armenian**

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Yuav muaj ib tug neeg txhais lus thiab nyeem cov ntawm ua lus Hmoob rau koj. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-244-6224 rau Cigna qhov kev pab them nqi kho mob/kho hniav los sis 1-866-421-8629 rau Cigna Kev Kaj Huv Ntawm Cev Kev Coj Cuj Pwm kev puas hlwb/kev siv tshuaj. Yog xav tau kev pab ntxiv hu rau CA Lub Caj Meem Fai Saib Xyuas Txog Kev Tuav Pov Hwm ntawm 1-800-927-4357. **Hmong**

You may get the required claim forms from the website listed on your identification card or by 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 180 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 180 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.

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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.

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 20 hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

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

First of the month following date of hire upon completion of all forms by the District accompanied by the verification of documents.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, 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.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you are eligible for coverage through a guarantee association and you elect the insurance more than 60 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

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.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you are a dependent who has lost or will lose coverage under Medi-Cal, the Healthy Families Program (HFP), or the Access for Infants and Mothers Program (AIM) and you elect the insurance more than 60 days after you become eligible and you declined coverage during your initial enrollment period by signing a Declination of Medical Coverage form, provided by your Employer; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns and Adopted Children

Any Dependent child born or placed for adoption, while you are insured will become insured on the date of his birth or placement for adoption, if you elect Dependent Insurance no later than 31 days after his birth or placement for adoption. If you do not elect to insure your newborn child or child placed for adoption within 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

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Important Information About Your Medical Plan

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

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician



you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

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.

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Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus 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, Deductible or Coinsurance.

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 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.

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for covered services. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

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, Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule. When the Out-of-Pocket Maximum 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.
- Plan Deductible.
- Any coinsurance, copayments 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 copayments 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.
- Any copayments and/or benefit deductibles not listed above as accumulating to the Out-of-Pocket maximum.
- Provider charges in excess of the Maximum Reimbursable Charge.

Open Access Plus Medical Benefits

The Schedule

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and 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.

Multiple Surgical Reduction

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.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
The Percentage of Covered Expenses the Plan Pays Note: "No charge" means an insured person is not required to pay Coinsurance.	80%	60% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Maximum Reimbursable Charge</p> <p>Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or</p> <p>A percentage of a schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:</p> <ul style="list-style-type: none"> • the provider's normal charge for a similar service or supply; or • the 80th 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 the Insurance Company. <p>Note: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.</p>	<p>Not Applicable</p>	<p>110%</p>
<p>Calendar Year Deductible</p> <p>Individual</p> <p>Family Maximum</p> <p>Family Maximum Calculation</p> <p>Individual Calculation: Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.</p>	<p>\$250 per person</p> <p>\$750 per family</p>	<p>\$400 per person</p> <p>\$1,200 per family</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Out-of-Pocket Maximum</p> <p>Individual</p> <p>Family Maximum</p> <p>Family Maximum Calculation</p> <p>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%.</p>	<p>\$3,000 per person</p> <p>\$9,000 per family</p>	<p>\$5,000 per person</p> <p>\$10,000 per family</p>
<p>Combined Medical/Pharmacy Out-of-Pocket Maximum</p> <p>Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery prescription drugs</p> <p>Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>In-Network coverage only</p>
<p>Physician's Services</p> <p>Primary Care Physician's Office Visit</p> <p>Specialty Care Physician's Office Visits</p> <p> Consultant and Referral Physician's Services</p> <p>Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.</p> <p>Surgery Performed in the Physician's Office</p> <p>Second Opinion Consultations (provided on a voluntary basis)</p> <p>Allergy Treatment/Injections</p> <p>Allergy Serum (dispensed by the Physician in the office)</p>	<p>No charge after \$45 per office visit copay</p> <p>No charge after \$45 Specialist per office visit copay</p> <p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p> <p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p> <p>No charge after either the \$45 PCP or \$45 Specialist per office visit copay or the actual charge, whichever is less</p> <p>No charge</p>	<p>60% after plan deductible</p> <p>60% after plan deductible</p> <p>60% after plan deductible</p> <p>60% after plan deductible</p> <p>60% after plan deductible</p> <p>60% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Preventive Care Routine Preventive Care (for children through age 16) Immunizations (for children through age 16)	No charge No charge	60% after plan deductible 60% after plan deductible
Routine Preventive Care (for ages 17 and over) Immunizations (for ages 17 and over)	No charge No charge	In-Network coverage only In-Network coverage only
Mammograms, PSA, PAP Smear Preventive Care Related Services (i.e. “routine” services) Diagnostic Related Services (i.e. “non-routine” services)	No charge Subject to the plan’s x-ray & lab benefit; based on place of service	60% after plan deductible Subject to the plan’s x-ray & lab benefit; based on place of service
Inpatient Hospital - Facility Services Semi-Private Room and Board Private Room Special Care Units (ICU/CCU)	\$250 per admission copay, then 80% after plan deductible Limited to the semi-private room negotiated rate Limited to the semi-private room negotiated rate Limited to the negotiated rate	\$500 per admission deductible, then 60% after plan deductible Limited to the semi-private room rate Limited to the semi-private room rate Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	80% after plan deductible	60% after plan deductible
Inpatient Hospital Physician’s Visits/Consultations	80% after plan deductible	60% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after plan deductible	60% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after plan deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Emergency and Urgent Care Services</p> <p>Physician's Office Visit</p> <p>Hospital Emergency Room</p> <p>Outpatient Professional Services (radiology, pathology and ER Physician)</p> <p>Urgent Care Facility or Outpatient Facility</p> <p>X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)</p> <p>Independent x-ray and/or Lab Facility in conjunction with an ER visit</p> <p>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)</p> <p>Ambulance</p>	<p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p> <p>No charge after \$250 per visit copay* and plan deductible *waived if admitted</p> <p>No charge after plan deductible</p> <p>No charge after \$50 per visit copay* and plan deductible *waived if admitted</p> <p>No charge after plan deductible</p> <p>No charge after plan deductible</p> <p>No charge after plan deductible</p> <p>No charge after plan deductible</p> <p>80% after plan deductible</p>	<p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p> <p>No charge after \$250 per visit copay* and plan deductible *waived if admitted</p> <p>No charge after plan deductible</p> <p>No charge after \$50 per visit copay* and plan deductible *waived if admitted</p> <p>No charge after plan deductible</p> <p>No charge after plan deductible</p> <p>No charge after plan deductible</p> <p>80% after plan deductible</p>
<p>Inpatient Services at Other Health Care Facilities</p> <p>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</p> <p>Calendar Year Maximum: 100 days combined</p>	<p>80% after plan deductible</p>	<p>60% after plan deductible</p>
<p>Laboratory and Radiology Services (includes pre-admission testing)</p> <p>Physician's Office Visit</p> <p>Outpatient Hospital Facility</p> <p>Independent X-ray and/or Lab Facility</p>	<p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p> <p>No charge</p> <p>No charge</p>	<p>60% after plan deductible</p> <p>60% after plan deductible</p> <p>60% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p>	<p>No charge</p> <p>\$250 per admission copay, then 80% after plan deductible</p> <p>80% after plan deductible</p>	<p>60% after plan deductible</p> <p>\$500 per admission deductible, then 60% after plan deductible</p> <p>60% after plan deductible</p>
<p>Outpatient Short-Term Rehabilitative Therapy</p> <p>Calendar Year Maximum: 20 days for all therapies combined</p> <p>Note: The Short-Term Rehabilitative Therapy maximum does not apply to the treatment of autism.</p> <p>Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy</p>	<p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p> <p>Note: Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.</p>	<p>60% after plan deductible</p>
<p>Outpatient Cardiac Rehabilitation</p> <p>Calendar Year Maximum: 36 days</p>	<p>No charge after the \$45 Specialist per office visit copay</p>	<p>60% after plan deductible</p>
<p>Chiropractic Care</p> <p>Calendar Year Maximum: 20 days</p> <p>Physician's Office Visit</p>	<p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p>	<p>60% after plan deductible</p>
<p>Acupuncture</p> <p>Calendar Year Maximum: 12 days</p>	<p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p>	<p>60% after plan deductible</p>
<p>Home Health Care</p> <p>Calendar Year Maximum: 100 days (includes outpatient private nursing when approved as Medically Necessary)</p>	<p>80% after plan deductible</p>	<p>60% after plan deductible</p>
<p>Hospice</p> <p>Inpatient Services</p> <p>Outpatient Services (same coinsurance level as Home Health Care)</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p>	<p>60% after plan deductible</p> <p>60% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Bereavement Counseling Services provided as part of Hospice Care</p> <p>Inpatient</p> <p>Outpatient</p> <p>Services provided by Mental Health Professional</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>Covered under Mental Health Benefit</p>	<p>60% after plan deductible</p> <p>60% after plan deductible</p> <p>Covered under Mental Health Benefit</p>
<p>Maternity Care Services Initial Visit to Confirm Pregnancy</p> <p>Note: OB/GYN providers will be considered either as a PCP or Specialist depending on how the provider contracts with the Insurance Company.</p> <p>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)</p> <p>Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist</p> <p>Delivery - Facility (Inpatient Hospital, Birthing Center)</p>	<p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p> <p>80% after plan deductible</p> <p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p> <p>\$250 per admission copay, then 80% after plan deductible</p>	<p>60% after plan deductible</p> <p>60% after plan deductible</p> <p>60% after plan deductible</p> <p>\$500 per admission deductible, then 60% after plan deductible</p>
<p>Abortion Includes elective and non-elective procedures</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p> <p>\$250 per admission copay, then 80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p>	<p>60% after plan deductible</p> <p>\$500 per admission deductible, then 60% after plan deductible</p> <p>60% after plan deductible</p> <p>60% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Women’s Family Planning Services</p> <p>Office Visits, Lab and Radiology Tests and Counseling</p> <p>Note: Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician’s office.</p> <p>Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)</p> <p>Physician’s Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician’s Services</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>60% after plan deductible</p> <p>60% after plan deductible</p> <p>\$500 per admission deductible, then 60% after plan deductible</p> <p>60% after plan deductible</p> <p>60% after plan deductible</p>
<p>Men’s Family Planning Services</p> <p>Office Visits, Lab and Radiology Tests and Counseling</p> <p>Surgical Sterilization Procedures for Vasectomy (excludes reversals)</p> <p>Physician’s Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician’s Services</p>	<p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p> <p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p> <p>\$250 per admission copay, then 80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p>	<p>60% after plan deductible</p> <p>60% after plan deductible</p> <p>\$500 per admission deductible, then 60% after plan deductible</p> <p>60% after plan deductible</p> <p>60% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Infertility Treatment Services Not Covered include:</p> <ul style="list-style-type: none"> • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). <p>Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.</p>	Not Covered	Not Covered
<p>Organ Transplants Includes all medically appropriate, non-experimental transplants</p> <p>Physician’s Office Visit</p> <p>Inpatient Facility</p> <p>Physician’s Services</p> <p>Lifetime Travel Maximum: \$10,000 per transplant</p>	<p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p> <p>100% at Lifesource center after \$250 per admission copay, otherwise 80% after \$250 per admission copay and plan deductible</p> <p>100% at Lifesource center, otherwise 80% after plan deductible</p> <p>No charge (only available when using Lifesource facility)</p>	<p>In-Network coverage only</p> <p>In-Network coverage only</p> <p>In-Network coverage only</p> <p>In-Network coverage only</p>
<p>Durable Medical Equipment Calendar Year Maximum: Unlimited</p>	80% after plan deductible	60% after plan deductible
<p>External Prosthetic Appliances Calendar Year Maximum: Unlimited</p>	80% after plan deductible	60% after plan deductible
<p>Hearing Aids Maximum: \$5,000 per 36 months</p>	80% after plan deductible	60% after plan deductible
<p>Diabetic Equipment Calendar Year Maximum: Unlimited</p>	80% after plan deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Nutritional Evaluation</p> <p>Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of diabetes.</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p> <p>\$250 per admission copay, then 80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p>	<p>60% after plan deductible</p> <p>\$500 per admission deductible, then 60% after plan deductible</p> <p>60% after plan deductible</p> <p>60% after plan deductible</p>
<p>Dental Care</p> <p>Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>No charge after the \$45 PCP or \$45 Specialist per office visit copay</p> <p>\$250 per admission copay, then 80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p>	<p>60% after plan deductible</p> <p>\$500 per admission deductible, then 60% after plan deductible</p> <p>60% after plan deductible</p> <p>60% after plan deductible</p>
<p>Routine Foot Disorders</p>	<p>Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.</p>	<p>Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.</p>
<p>Treatment Resulting From Life Threatening Emergencies</p> <p>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 abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.</p>		
<p>Mental Health</p> <p>Inpatient</p> <p>Outpatient (Includes Individual, Group and Intensive Outpatient)</p> <p>Physician's Office Visit</p> <p>Outpatient Facility</p>	<p>\$250 per admission copay, then 80% after plan deductible</p> <p>\$45 per visit copay</p> <p>80% after plan deductible</p>	<p>\$500 per admission deductible, then 60% after plan deductible</p> <p>60% after plan deductible</p> <p>60% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Substance Abuse Inpatient Outpatient (Includes Individual and Intensive Outpatient) Physician’s Office Visit Outpatient Facility	\$250 per admission copay, then 80% after plan deductible \$45 per visit copay 80% after plan deductible	\$500 per admission deductible, then 60% after plan deductible 60% after plan deductible 60% after plan deductible

Open Access Plus 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 a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for Mental Health or Substance Abuse 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 be reduced by 50% for 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 not include:

- 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 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 nonemergency 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 be reduced by 50% for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or 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.

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Hysterectomy.

Continuity of Care

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

- **an acute condition.** An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Completion of covered services shall be provided for the duration of the acute condition.

- **a serious chronic condition.** A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Cigna in consultation with you and the terminated Participating Provider or non-Participating Provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered person.
- **a pregnancy.** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
- **a terminal illness.** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness.
- The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered person.
- performance of a surgery or other procedure that is authorized by Cigna as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered person.

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

Cigna is not obligated to arrange for continuity of care with a terminated Participating Provider or non-Participating Provider who has been terminated for medical disciplinary

reasons or who has committed fraud or other criminal activities.

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

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

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

To make a request for continuity of care, please call the number on your I.D. card as early as possible so the review process can begin and your treatment can continue.

HC-PAC8

10-14

HC-PAC1

V2

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;
- intensive outpatient programs;

- advanced radiological imaging;
- non-emergency ambulance; or
- transplant services.

HC-PRA1

11-14

V5

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. **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 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 anesthetics 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 or in connection with mammograms for breast cancer screenings or diagnostic purposes including, but not limited to: a baseline mammogram for women age 35, but less than 40; a mammogram for women age 40, but less than 50, every two years or more, if medically necessary and if recommended by a Physician, nurse practitioner or a nurse midwife; and a mammogram every year for women age 50 and over.
- charges made for an annual Papanicolaou laboratory screening test.
- charges for the screening and diagnosis of prostate cancer, including, but not limited to, Medically Necessary prostate-specific antigen testing and digital rectal examinations;
- charges made for services related to the diagnosis, treatment, and management of osteoporosis. Covered services include, but are not limited to, all FDA approved technologies, including bone mass measurement technologies as deemed Medically Necessary.

In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below for a Dependent child who is age 16 or less, for charges made for Child Preventive Care consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

- physical examinations;
- appropriate immunizations; and
- laboratory tests in connection with physical examinations.

excluding any charges for:

- more than one visit to one provider for Child Preventive Care Services at each of the Appropriate 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; or
- services for which benefits are not payable according to the "Expenses Not Covered" section.

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 16 years.

- HIV testing regardless of whether testing is related to the patient's primary diagnosis.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.

- charges made for professional services and treatment programs for Pervasive Developmental Disorders or Autism, including applied behavior analysis (ABA), and evidence-based behavior intervention programs, that develop or restore to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or Autism and that meet all of the following criteria:
 - the treatment is prescribed by a licensed Physician or is developed by a licensed Psychologist;
 - the treatment is provided under a treatment plan prescribed by a Qualified Autism Service Provider and is administered by one of the following:
 - a Qualified Autism Provider.
 - a Qualified Autism Service Professional supervised and employed by a Qualified Autism Provider
 - a Qualified Autism service Paraprofessional supervised and employed by a Qualified Autism Service Provider.
 - the treatment plan has measurable goals over a specific time-line that is developed and approved by the Qualified Autism Provider for the specific patient. The treatment plan should be reviewed no less than every 6 months by the Qualified Autism Provider and modified when appropriate. Within the treatment plan the Qualified Autism Provider shall do all of the following:
 - describe the patient's behavioral health impairments to be treated.
 - design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goals and objectives, and the frequency at which the patient's progress is evaluated and reported.
 - provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorders or Autism.
 - discontinue intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
 - the treatment plan is not used for purposes of providing/reimbursing respite care, day care or educational services and is not used to reimburse a parent for participating in the treatment program.

Pervasive Developmental Disorders or Autism means Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified (including Atypical Autism), in accordance with the Diagnostic and Statistical Manual for Mental Disorders -IV - Text Revision (June 2000).

Qualified Autism Service Provider means either:

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

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

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

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

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

- charges made for Telehealth Services. Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, treatment, education, care management, and self-management of a patient's health care while the patient is at the Originating Site and the Provider for Telehealth is at a Distant Site. Telehealth facilitates patient self-management and caregiver support for patients and includes:
 - Synchronous Interactions; Synchronous Interaction means a real-time interaction between a patient and a Health Care Provider for Telehealth located at a Distant Site; and
 - Asynchronous Store and Forward transfers; Asynchronous Store and Forward means the transmission of a patient's medical information from an Originating Site to the Health Care Provider for Telehealth at a Distant Site without the presence of the patient.

Originating Site means a site where a patient is located at the time health care services are provided via telecommunications system or where the Asynchronous Store and Forward service originates.

Distant Site means a site where a Health Care Provider for Telehealth who provides health care services is located while providing these services via a telecommunications system.

- coverage for the testing and treatment of PKU. This includes formulas and special food products that are part of a diet prescribed by a Physician and managed by a health care professional in consultation with a Physician specializing in the treatment of metabolic diseases. The diet must be deemed Medically Necessary to avoid the development of serious mental or physical disabilities or to promote normal development or function resulting from PKU.

Formula means an enteral product used in the home and prescribed by a Physician, nurse practitioner, or registered dietician for medically necessary treatment of PKU. Special food products are those that are prescribed by a Physician or Nurse practitioner for the treatment of PKU and are consistent with the recommendations and best practices of qualified health professionals with expertise in treatment and care of PKU. It does not include a food that is naturally low in protein. It may include a food product that is specially formulated to have less than one gram of protein per serving and is used instead of normal food products used by the general population, such as grocery store foods.

- charges made for Medically Necessary treatment of Severe Mental Illness for covered persons of any age, and Serious Emotional Disturbances of a Dependent Child under 18 years old.

- charges made for prosthetic appliances, including devices to restore a method of speaking following a laryngectomy, other than electronic voice-producing machines.
- charges made by a licensed social worker, a registered Nurse licensed in psychiatric-mental health or a licensed marriage, family or child counselor, for Mental Health services, when such services are recommended by a Physician.
- charges for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following a cesarean section for both mother and newborn. The mother and/or newborn may be discharged earlier if the Physician consults with the mother. If discharged early, there will be at least one follow-up visit within 48 hours of discharge. Follow-up care may be in the mother's home, in the Physician's office, or in a licensed facility. An additional length of stay beyond the 48/96 hours will be covered if Medically Necessary.

The following describes coverage provided for the treatment of diabetes:

- charges for the following Medically Necessary equipment for the management and treatment of insulin-using diabetes, noninsulin-using diabetes, and gestational diabetes: blood glucose monitors; blood glucose monitors designed to assist the visually impaired; insulin pumps and all related necessary supplies; podiatric devices to prevent or treat diabetes-related complications; and visual aids (not including eyewear) to assist the visually impaired with proper dosing of insulin.
- charges for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to allow a covered person to properly use the equipment, supplies, and medications listed previously, and any additional diabetes outpatient self-management training, education, and medical nutrition therapy prescribed by or directed by a Physician.
- charges for insulin, insulin syringes, Prescriptive medications for the treatment of diabetes, lancets and lancet puncture devices, blood glucose testing strips, ketone urine testing strips, pen delivery systems for the administration of insulin and Glucagon.
- charges for cancer screening tests that are based on generally accepted medical guidelines or scientific evidence.
- charges for prenatal testing resulting from participation in the Expanded Alpha Feto Protein program administered by the State Department of Health Services.
- charges for general anesthesia and associated facility charges for dental procedures rendered in a Hospital or Ambulatory Surgical Facility for: a child under the age of 7; an individual who is developmentally disabled; or an

individual whose health is compromised and general anesthesia is Medically Necessary.

- charges for a Hospital stay resulting from a mastectomy and/or lymph node dissection for a period of time determined by a Physician in consultation with the patient.
- charges made for a drug that has been prescribed for purposes other than those approved by the FDA will be covered if:
 - the drug is otherwise approved by the FDA;
 - the drug is used to treat a life-threatening condition or, a chronic and seriously debilitating condition and the drug is Medically Necessary to treat that condition;
 - the drug has been recognized for the treatment prescribed by any of the following: the American Hospital Formulary Service Drug Information, one of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology; The National Comprehensive Cancer Network Drug and Biologics compendium; The Thomson Micromedex Drug Dex; or two articles from major peer reviewed medical journals that present data supporting the proposed use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

Second Opinions

You or your Physician may request a second opinion relating to a medical treatment or surgical procedure. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

- if you question the reasonableness or necessity of recommended surgical procedures.
- if you question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
- if the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and you request an additional diagnosis.
- if the treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment.
- if you have attempted to follow the plan of care or consulted with your initial provider concerning serious concerns about the diagnosis or plan of care.

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

Appropriately Qualified Health Care Professional

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

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

- if you request a second opinion about care from your Primary Care Physician, the second opinion shall be provided by an Appropriately Qualified Health Care Professional, of your choice within the primary care Physician's medical group.
- if you are requesting a second opinion about care from a Specialist, you may obtain the second opinion from any Qualified Health Care Professional of the same or equivalent specialty of your choice. If not authorized by Cigna or the Primary Care Physician's medical group, additional medical opinions not within the Primary Care Physician's medical group shall be your responsibility.

In approving a second opinion the Physician and/or Cigna shall take into account your ability to travel to the provider. Cigna shall require the second opinion health professional to provide you and the initial health professional with a consultation report, including any recommended procedures or tests that the second opinion health professional believes appropriate.

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

- 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.
- charges made for surgical or nonsurgical treatment of Temporomandibular Joint Dysfunction.
- charges for federal Food and Drug Administration (FDA)-approved prescription contraceptive methods, as designated by Cigna. If your Physician determines that none of the methods designated by Cigna are medically appropriate for you because of your medical or personal history, Cigna will cover the alternative FDA-approved prescription contraceptive prescribed by your Physician;

Clinical Trials

Charges made for a covered person diagnosed with cancer and accepted into a phase I through phase IV clinical trial for cancer if the treating Physician recommends participation in clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the covered person. The clinical trial must meet the following requirements:

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

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

- services typically provided absent a clinical trial.

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

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. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing.

Nutritional Evaluation

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 nonfunctional 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.

HC-COV3

04-10
V1

Cardiac Rehabilitation

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

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

HC-COV4

04-10
V1

Home Health Services

- charges made for Home Health Services when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility.

Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing,

eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

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

HC-COV76

04-10
V1

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.

HC-COV78

04-10

V1

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

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 Partial Hospitalization and Mental Health Residential Treatment Services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

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 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.

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

Inpatient Substance Abuse 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 Abuse Services include Partial Hospitalization sessions and Residential Treatment services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Substance Abuse 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 Abuse conditions.

Substance Abuse Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; 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 Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse 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 Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. 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 Abuse 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 Abuse Services:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this 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.

HC-COV7

04-10

V4

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

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, respirators, wheel chairs, and dialysis machines.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric

chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.

- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

HC-COV8

04-10
v2

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

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

Prostheses/Prosthetic Appliances and Devices

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

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Orthoses and Orthotic Devices

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

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
 - rigid and semirigid custom fabricated orthoses;
 - semirigid prefabricated and flexible orthoses; and
 - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
 - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
 - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
 - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
 - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

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

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.

- replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
 - no more than once every 24 months for persons 19 years of age and older;
 - no more than once every 12 months for persons 18 years of age and under; and
 - replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

HC-COV9

02-14
v8

Short-Term Rehabilitative Therapy

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.

Multiple outpatient services provided on the same day constitute one day.

A separate Copayment will apply to the services provided by each provider.

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

The following limitation applies to Chiropractic Care Services:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- vitamin therapy.

HC-COV13

04-10
v2

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 nondiseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

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. Reconstructive Surgery also includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate means a condition that may include cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate. 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.

HC-COV77

04-10

V1

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 or its territories. 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, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities.

Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, 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, 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 reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a 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); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to 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. The following are specifically excluded travel expenses: travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

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

HC-COV15

04-10

V2

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.		
Copayments		
Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies.		
Oral Chemotherapy Medication		
Prescription oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered at Participating Pharmacies at 100% with no deductible and at Non-Participating Pharmacies, the same as the out of network medical cost share for injectable/IV chemotherapy.		
BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Out-of-Pocket Maximum		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Retail Prescription Drugs	The amount you pay for each 30-day supply	The amount you pay for each 30-day supply
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.		
Tier 1		
Generic* drugs on the Prescription Drug List	No charge after \$5 copay	In-network coverage only
Tier 2		
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after \$35 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 \$50 copay	In-network coverage only

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		
Home Delivery Prescription Drugs	The amount you pay for each 90-day supply	The amount you pay for each 90-day supply
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.		
Tier 1 Generic* drugs on the Prescription Drug List	No charge after \$5 copay	In-network coverage only
Tier 2 Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after \$35 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 \$50 copay	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

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 Participating 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.

HC-PHR1

04-10
V2

In the event that you insist on a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the required Copayment identified in the Schedule.

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific

condition. If your Physician wishes to request coverage for 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.

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 and 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.

HC-PHR2

04-10
V6

Your Payments

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

to the Schedule for any required Copayments, Coinsurance, Deductibles or Maximums if applicable.

When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for your, or your Dependent's convenience, a Copayment will apply to each Prescription Drug.

HC-PHR3

04-10

V2

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;
- charges made for a drug that has been prescribed for purposes other than those approved by the FDA unless:
 - the drug is otherwise approved by the FDA;
 - the drug is used to treat a life-threatening condition or, a chronic and seriously debilitating condition and the drug is Medically Necessary to treat that condition;
 - the drug has been recognized for the treatment prescribed by any of the following: the American Hospital Formulary Service Drug Information, one of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen; The Elsevier Gold Standard's Clinical Pharmacology; The National Comprehensive Cancer Network Drug and Biologics compendium; The Thomson Micromedex Drug Dex; or two articles from major peer reviewed medical journals that present data supporting the proposed use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- any fertility drug;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasm, and decreased libido;
- prescription vitamins (other than prenatal vitamins), dietary supplements unless state or federal law requires coverage of such drugs;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- 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;
- 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.

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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, Coinsurance or Deductible shown in the Schedule at the time of purchase. You do not need to file a claim form unless you are unable to purchase Prescription Drugs at a Participating Pharmacy for Emergency Services.

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.

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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, or undeclared.
- 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.
- 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 abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

- 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;

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) 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 clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance. Cosmetic surgery and therapy does not include gender reassignment services.
- the following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, (unless services are an integral part of reconstructive surgery for Cleft Palate), periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance 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.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, 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.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays or mental retardation.
- 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.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass 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 noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription 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 unless services are an integral part of reconstructive surgery for Cleft Palate.
- 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 nonparticipating provider.
- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- 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.

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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 copayments, 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, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles

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

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

whose insurance is continued for any reason as provided in this plan;

- (c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;
- (d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;
- (e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;
- (f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

Cigna will assume the amount payable under:

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

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

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

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan when Medicare coverage is due to age. Therefore, when Medicare coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and Cigna is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer rules explained above will apply.

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.

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, if the plan is governed by ERISA. 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.

- the methodologies as reported by generally recognized professionals or publications.

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Payment of Benefits

To Whom Payable

Medical Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

Ambulance benefits will be paid directly to the provider of the ambulance service.

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.

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,

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.
- a year after your death for your Active & Early Retiree spouses and/or children.
- until end of September if terminated on the month of June otherwise 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 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 stops paying premium for you or otherwise cancels your insurance.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels the insurance.

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.

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Continuation of Coverage Under Cal-COBRA

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

Employer groups with 20 or more Employees

You and your Dependents may elect to continue health coverage after you have exhausted continuation coverage under COBRA. Cal-COBRA is not applicable to Domestic Partners and their Dependents or to stepchildren. This continuation coverage (Cal-COBRA) will be provided for up to 36 months from the date your COBRA continuation coverage began, if you are entitled to less than 36 months of continuation coverage under COBRA.

Employer groups with less than 20 Employees

This Continuation applies to you and your Dependents if your Employer is subject to Cal-COBRA law. Cal-COBRA is not applicable to Domestic Partners and their Dependents or to stepchildren. Cal-COBRA law applies to any small Employer that employed 2 to 19 eligible Employees on at least 50 percent of its working days during the preceding calendar year, or, if the Employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible Employees on at least 50 percent of its working days during the preceding calendar quarter. This continuation coverage will be provided for up to 36 months from the date of the Qualifying Event.

Notice Requirements

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

Qualifying Events for Continuation of Cal-COBRA Coverage

A **Qualifying Event** is any of the following:

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

Notification Requirements

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

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

To be eligible for continuation coverage, for one of the Qualifying Event(s) you or your Dependent must notify Cigna (or an administrator acting on Cigna's behalf) in writing of such Qualifying Event within 60 days after the event occurs.

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

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

Formal Election

To continue group coverage under Cal-COBRA you must make a formal election by submitting a written request to Cigna (or an administrator acting on Cigna's behalf) at: Cigna, Attn: State Continuation Unit, P.O. Box 2010, Concord, NH 03302. For questions, call 1-800-315-6011.

The written request must be delivered by first-class mail, certified mail or other reliable means of delivery within 60 days of the later of the following dates:

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

If a formal election is not received by Cigna (or an administrator acting on Cigna's behalf) within this time period, you or your Dependent will not receive Cal-COBRA benefits.

Cal-COBRA Premium Payments

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

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

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

- the date the Employer ceases to provide any group health plan to any Employee;
- the end of the period for which premium payments were made, if the qualified beneficiary ceases to make payments or fails to make timely payments of a required premium, in accordance with the terms and conditions of the policy;

- the first day after the date of election on which the qualified beneficiary first becomes covered under any other group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition for such person; or the date such exclusion or limitation no longer applies to the Employee or Dependent;
- the first day after the date of election on which the qualified beneficiary first becomes entitled to Medicare;
- the coverage for a qualified beneficiary that is determined to be disabled under the Social Security Act will terminate as described below;
- the qualified beneficiary moves out of the service area or the qualified beneficiary commits fraud or deception in the use of services.

Continuation of Coverage for Totally Disabled Individuals

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

Continuation of Coverage Upon Termination of Prior Group Health Plan

The Employer shall notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered as specified above, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would

have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled Employees are notified, whichever is later.

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

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

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

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

HC-TRM16

04-10
V2

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.

HC-TRM80

01-11

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 or Sickness, Medical Benefits will be paid without requirement of premium for Covered Expenses incurred in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group policy;
- the date you are no longer Totally Disabled;
- 12 months from the date your Medical Benefits cease;
- 12 months from the date the policy is canceled.

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.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when your or your Dependent's Medical Benefits cease.

HC-BEX7

04-10
V1

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.

HC-FED1

10-10

Notice of Provider Directory/Networks

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

If your Plan uses a network of Providers, a separate listing of Participating Providers/Pharmacies who participate in the network is available to you without charge by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are employed by or contracted with Cigna HealthCare.

HC-FED2

10-10 M

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.

HC-FED4

10-10

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.
- **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 on the first day of the 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:

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

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.

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.

G. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in Qualified Health Plan (QHP)

The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

HC-FED70

12-14

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, 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.

HC-FED67

09-14

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.

HC-FED10

10-10

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.

HC-FED12

10-10

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.

HC-FED13

10-10

Requirements of 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.

HC-FED17

10-10

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.

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.

HC-FED18

10-10 M

Claim Determination Procedures

The following complies with federal law. Provisions of the laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice Medical Necessity determination." The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents, and in the determination notices.

Preservice Medical Necessity Determinations

When you or your representative request a required Medical Necessity determination prior to care, 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 Physician 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's Physician will defer to the determination of the treating Physician, 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 fails to follow Cigna's procedures for requesting a required preservice Medical Necessity 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 Medical Necessity Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, 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.

Postservice Claim Determinations

When you or your representative requests payment for services which have been rendered, Cigna will notify you of the claim payment 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 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 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; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; 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, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; 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; 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.

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.

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.

HC-FED66

07-14

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

Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual’s state of residence.

HC-FED53

10-13

Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

HC-SPP4

04-10

V1

When You Have A Complaint Or An Adverse Determination Appeal

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

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Customer Service

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 can call our toll-free number and

explain your concern to one of our Customer Service representatives. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form.

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

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

Internal Appeal Procedure

Cigna has a one-step appeal procedure for appeals decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

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.

We will respond in writing with a decision within 30 calendar days after we receive an appeal for a required pre-service or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a post-service 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 30 calendar days and to specify any additional information needed to complete the review. Please note that the California Department of Insurance (CDI) does not require you to participate in Cigna's appeals review for more than 30 days although you may choose to do so. At the completion of this 30-day-review period, when the disputed decision is upheld or your case remains unresolved, you may apply to the CDI for a review of your case.

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

sufficiently in advance of the decision so that you will have an opportunity to respond.

You may request that the appeal process be expedited if, your treating Physician certifies in writing that an imminent and serious threat to your health may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health.

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 internal appeal would be detrimental to your medical condition.

When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing. The CDI allows you to apply for an independent medical review after this expedited decision if you are unsatisfied with our determination.

Independent Medical Review Procedures

When the disputed decision is upheld or your case remains unresolved after 30 days and when your case meets the criteria outlined below, you are eligible to apply to the CDI for an Independent Medical Review (IMR). The CDI has final authority to accept or deny cases for the IMR process. If your case is not accepted for IMR, the CDI will treat your application as a request for the CDI itself to review your issues and concerns. Prior to application for an IMR, you are free to seek other avenues of appeal with Cigna. If you choose to do so, you will not forfeit your eligibility to apply for the IMR.

The Independent Medical Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the Policy.

There is no charge for you to apply for or participate in this IMR process. Cigna will abide by the decision of the Independent Medical Review Organization.

In order to qualify for an IMR, certain conditions must be met: your Physician has recommended a health care service as Medically Necessary and Cigna has disagreed with this determination, or you have received urgent care or emergency services that a Physician has deemed Medically Necessary and Cigna has disagreed with this determination, or you have been seen by a Physician for the diagnosis or treatment of the medical condition for which you are seeking an independent medical review and Cigna has determined these services as not Medically Necessary or clinically appropriate. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for an independent medical appeal under this process. You remain entitled to send such issues to the CDI for a Department review.

Independent Review Process for Experimental and Investigational Therapies

Special provisions apply to the IMR process for coverage decisions related to experimental or investigational therapies. If Cigna denies your appeal because the requested service or treatment is experimental or investigational, Cigna will send you a letter within 5 business days of making the denial decision. The letter will include:

- a notice explaining your right to an IMR;
- an IMR application;
- a Physician Certification Form for your Physician to complete which certifies that you have a life-threatening or seriously debilitating condition; your Physician's certification must also indicate that standard therapies have not been effective in treating your condition or the requested therapy is likely to be more beneficial than any standard therapy as documented in two separate sources of medical or scientific evidence;
- an envelope for you to return the completed forms to us.

A "life-threatening" condition means either or both of the following:

- diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.
- a "seriously debilitating" condition means diseases or conditions that cause major irreversible morbidity.

"Medical and scientific evidence" means any of the following:

- peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
- peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS data base Health Services Technology Assessment Research (HSTAR).
- medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.
- either of the following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Dental Association Accepted Dental Therapeutics and The United States Pharmacopoeia-Drug Information.
- any of the following reference compendia if recognized by the Federal Center for Medicare and Medicaid Services as

part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology, The National Comprehensive Cancer Network Drug and Biologics Compendium, The Thomson Micromedex DrugDex.

- findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.
- peer-reviewed abstracts accepted for presentation at major medical association meetings.

The IMR will be conducted by an Independent Medical Review Organization which is qualified to review issues related to experimental and investigational therapies as selected by the CDI. The IMR must be completed within 30 calendar days. If your physician determines that the proposed therapy which is the subject of the IMR would be significantly less effective if not initiated promptly, an expedited IMR is available. An expedited IMR will be completed within 7 calendar days from the date an expedited IMR was requested. This timeframe may be extended by up to 3 calendar days if there is a delay in providing any documents which the Independent Medical Review Organization requests for review. The IMR's decision must state the reason that the therapy should or should not be covered, citing your specific medical condition, the relevant documents, and the relevant medical and scientific evidence. Cigna will cover the services subject to the terms and conditions generally applicable to other benefits under your policy.

Appeal to the State of California

We will provide you with an application and instructions on how to apply to the CDI for an IMR. You must submit the application to the CDI within 180 days of your receipt of our appeal review denial. In compelling circumstances, the Commissioner of Insurance may grant an extension.

The Independent Medical Review Organization will render an opinion within 30 days. If a delay would be detrimental to your medical condition, you may apply to the Department for an expedited review of your case. If accepted, the Independent Medical Review Organization will render a decision in three days.

You have the right to contact the California Department of Insurance for assistance at any time. The Commissioner may be contacted at the following address and fax number:

California Department of Insurance
Claims Service Bureau, Attn: IMR
300 South Spring Street
Los Angeles, CA 90013
or fax to 213-897-5891

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the denial decision; reference to the specific Policy provisions on which the decision 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 and the claimant's right to bring an action under ERISA section 502(a); 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 adverse determination will include a discussion of the decision.

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

Relevant Information

Relevant Information is any document, record, or other information which was 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; demonstrate 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 Policy concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the appeal processes. However, no action will be brought at all unless brought within three years after proof of claim is required under the Plan. However, no action will be brought at all unless brought within three years after a claim is submitted for In-Network services or within three years after proof of claim is required under the Plan for Out-of-Network services.

HC-APL230

08-14

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.

HC-DFS1

04-10

V1

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.

HC-DFS2

04-10

V2

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount.

HC-DFS3

04-10

V1

Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

HC-DFSS5

04-10
V1

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.

HC-DFS4

04-10
V1

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
 - less than 26 years old.
 - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Cigna requires written proof of such disability and dependency within 60 days of receiving our request for written proof. After the original proof is received, Cigna may ask for proof of

handicap/dependency annually, after the two year period following the child's 26th birthday.

The term child means a child born to you, a child legally adopted by you from the date the child is placed in your physical custody prior to the finalization of the child's adoption, or a child supported by you pursuant to a court order (including a qualified medical child support order). It also includes a stepchild, a grandchild who lives with you, 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.

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

Anyone who is eligible as an Employee will not be considered as a Dependent.

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

HC-DFS158

04-10
V1

Domestic Partner

A Domestic Partner is defined as your Domestic Partner who has registered the domestic partnership by filing a Declaration of Domestic Partnership with the California Secretary of state pursuant to Section 298 of the Family Code or an equivalent document issued by a local agency of California, another state, or a local agency of another state under which the partnership was created.

The sections of this certificate entitled "COBRA Continuation Rights Under Federal Law" and "Continuation of Coverage under Cal-COBRA" will not apply to your Domestic Partner and his or her Dependents.

HC-DFS159

04-10
V1

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.

HC-DFS394 11-10

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.

HC-DFS393 11-10

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 20 hours a week for the Employer.

HC-DFS7 04-10
V3

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

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.

HC-DFS411 01-11

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

HC-DFS10 04-10
V1

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.

HC-DFS11 04-10
V1

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.

HC-DFS51 04-10
V1

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.

HC-DFS52 04-10
V1

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.

HC-DFS53 04-10
V1

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 Abuse 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.

HC-DFS48 04-10
V1

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 Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

HC-DFS49 04-10
V1

Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

Maintenance Treatment

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

HC-DFS56 04-10
V1

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 percentage of a schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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

In some cases, a Medicare based schedule will not be used and 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
- the 80th 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 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 is available upon request.

HC-DFS13 04-10
V8

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.

HC-DFS16 04-10
V1

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.

HC-DFS19 04-10
V1

Medicare

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

HC-DFS17 04-10
V1

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

HC-DFS21 04-10
V1

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."

HC-DFS22 04-10
V1

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,
Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS23 04-10
V1

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.

HC-DFS60 04-10
V1

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.

HC-DFS45 04-10
V1

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).

HC-DFS412 01-11

Pharmacy

The term Pharmacy means a retail Pharmacy, or a home delivery Pharmacy.

HC-DFS61 04-10
V1

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.

HC-DFS62 04-10
V1

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.

HC-DFS25 04-10
V1

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.

HC-DFS63 04-10
V1

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.

HC-DFS64 04-10
V1

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.

HC-DFS65 04-10
V1

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

HC-DFS57 04-10
V1

Primary Care Physician

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice, obstetrics/gynecology 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.

HC-DFS167 04-10
V2

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.

HC-DFS26 04-10
V1

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes

for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

HC-DFS68 04-10
V1

Review Organization

The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

HC-DFS30 04-10
V1

Serious Emotional Disturbances

A Seriously Emotionally Disturbed (SED) child shall be defined as a child who:

- has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance abuse disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms; and
- is under the age of 18 years old; and
- meets the criteria in as follows:
 - as a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
 - the child is at risk of removal from the home or has already been removed from the home;
 - the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
 - the child displays one of the following: psychotic features, risk of suicide or violence due to a mental disorder; or
 - the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

HC-DFS168 04-10
V2

Severe Mental Illness

A severe mental illness is defined as: schizophrenia; bipolar disorder; obsessive-compulsive disorder; major depressive disorders; panic disorder; anorexia nervosa; bulimia nervosa; schizoaffective disorder; and pervasive developmental disorder or autism.

HC-DFS169 04-10
V1

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.

HC-DFS50 04-10
V1

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.

HC-DFS31 04-10
V1

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.

HC-DFS33 04-10
V1

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.

HC-DFS413 01-11

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.

HC-DFS54 04-10
V1

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.

HC-DFS34 04-10
V1