Frederick County Government

OPEN ACCESS PLUS MEDICAL
BENEFITS
W/Health Saving Account

EFFECTIVE DATE: January 1, 2020

CN061
3334606

This document printed in February, 2020 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: Frederick County Government

GROUP POLICY(S) — COVERAGE
3334606 – HSAF, HSAI OPEN ACCESS PLUS MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2020

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 Krishtul

Anna Krishtul, 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.

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.

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.

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Provider Directory Notice

If you would like a list of Participating Providers, just call the toll free number for customer service that is on your Cigna HealthCare ID card or visit the Cigna HealthCare Web site at www.cigna.com.

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Important Information

Rebates and Other Payments

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

Coupons, Incentives and Other Communications

At various times, Cigna or its designee may send mailings to you or your Dependents or to your Physician that communicate a variety of messages, including information about Medical Pharmaceuticals and Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you or your Dependents, at your discretion, to purchase the described Medical Pharmaceutical and Prescription Drug Product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Cigna, its affiliates and the plan are not responsible in any way for any decision you make in connection with any coupon, incentive, or other offer you may receive from a pharmaceutical manufacturer or Physician.

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Discrimination is Against the Law

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

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

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

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

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

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HC-NOT96 07-17

Proficiency of Language Assistance Services

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

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

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

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

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

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

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY : اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

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

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

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

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

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711را شمارهگیری کنید).

HC-NOT97 07-17

Problems With Your Insurance? If you are having problems with your insurance company, do not hesitate to contact the insurance company to resolve your problem. Please call the number shown on your identification card or claim form.

You can also contact the **Maryland Insurance Administration** and file a complaint. You can contact them in writing or by telephone. Please write to:

Maryland Insurance Administration
Consumer Complaints & Investigation
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

or you can call 1-800-492-6116, or 410-468-2244 (Fax: 410-468-2260).

For plans with Participating Providers: To receive a directory of Participating Providers you may call the number on your Benefit Identification card or visit the web site at www.cigna.com.

Important Information About Your Pharmacy Benefits Plan

Generally, all non-Emergency Services care must be provided by a Participating Pharmacy to be covered. Emergency Services and care received in connection with an unforeseen illness, injury, or a condition requiring immediate care will always be covered as if received from a Participating Pharmacy, even if such care was received from a non-participating Pharmacy.

Standing Referral for Services by a Participating Specialist

You may receive a standing referral, to a participating Specialist, if: your Primary Care Physician determines, with the Specialist, that you need continuing care from the Specialist, you have a condition or disease that is life threatening, degenerative, chronic or disabling, and requires specialized medical care, and the Specialist has expertise in the treating such disease or condition.

A standing referral will be made in accordance with a written treatment plan for a covered service developed by your Primary Care Physician, the Specialist and you.

Referral For Services by a non-participating Specialist or non-Physician Specialist

You may receive a referral to a non-participating Specialist or non-Physician Specialist if: you are diagnosed with a condition or disease that requires specialized health care services or medical care; we do not have a participating Specialist or non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or we cannot provide reasonable access to a Specialist or non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel. Any deductible, copayment or coinsurance applicable to the services for which the referral is requested will be calculated as if the services were received from a Participating Provider.

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, your child's non-insuring parent, a state child support enforcement agency or the Maryland Department of Health and Mental Hygiene must notify your Employer and elect coverage for that child. If you yourself are not already enrolled, you must elect coverage for both yourself and your child. We will enroll both you and your child within 20 business days of our receipt of the QMCSO from your Employer.

Eligibility for coverage will not be denied on the grounds that the child: was born out of wedlock; is not claimed as a Dependent on the Employee's federal income tax return; does not reside with the Employee or within the plan's service area; or is receiving, or is eligible to receive, benefits under the Maryland Medical Assistance Program.

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.

Claims

Claims will be accepted from the non-insuring parent, from the child's health care provider or from the state child support enforcement agency. Payment will be directed to whoever submits the claim.

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.

Termination of Coverage Under a QMCSO

Coverage required by a QMCSO will continue until we receive written evidence that: the order is no longer in effect; the child is or will be enrolled under a comparable health plan which takes effect not later than the effective date of disenrollment; Dependent coverage has been eliminated for all Employees; or you are no longer employed by the Employer, except that if you elect to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage will be provided for the child consistent with the Employer's plan for postemployment health insurance coverage for Dependents.

Continuity of Health Care Notice

If you are a new enrollee, please read the following:

You are receiving this notice because you are a new enrollee and may be moving from Maryland Medical Assistance or another company's health benefit plan to a Cigna health benefit plan. If you currently are receiving treatment, you have special rights in Maryland.

For example, if your old company gave you pre-approval to have surgery or to receive other services, you may not need to receive new approval from us to proceed with the surgery or to continue receiving the same services. Also, if you are seeing a doctor or other health care provider who is an in-network provider with your old company, and that provider is not an in- network provider under your new plan, you may continue to see your provider for a limited period of time as though the provider were an in-network provider with us.

The rules on how you can qualify for these special rights are described below.

Prior approval for health care or dental services. If you previously were covered under another company's plan, a prior approval (also called "preauthorization") for services that you received under your old plan may be used to satisfy a prior approval requirement for those services if they are covered under your new plan with us. **To be able to use the old prior approval under this new contract, you will need to contact us at the phone number on the back of your ID card to let us know that you have a prior approval for the services and provide us with a copy of the prior approval**. Your parent, guardian, designee, or health care provider may also contact us on your behalf about the prior approval.

There is a time limit for how long you can rely on the prior approval. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health care practitioner after the baby is born.

If you do not have a copy of the prior approval, contact your old company and request a copy. Under Maryland law, your old company must provide a copy of the prior approval within 10 days of your request.

Right to use non-network providers. If you have been receiving services from a health care provider who was an in-network provider with your old company, and that provider is a non- network provider under your new health plan with us, you may be able to continue to see your provider as though the

provider were an in-network provider. You or someone acting on your behalf must contact us at the phone number on the back of your ID to request the right to continue to see the non-network provider as if the provider were an in-network provider with us.

This right applies only if you are being treated by the non-network provider for covered services for one or more of the following types of conditions:

- Acute conditions (including acute dental conditions);
- Serious chronic conditions (including serious chronic dental conditions);
- Pregnancy;
- Mental health conditions;
- Substance use disorders; or
- Any other condition upon which we and the out-of-network provider agree.

Examples of the conditions listed above include bone fractures, joint replacements, heart attacks, cancer, HIV/AIDS and organ transplants.

There is a time limit for how long you can continue to see a non-network provider and only need to pay cost-sharing as though the provider were an in-network provider. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health care practitioner after the baby is born.

Example of how the right to use non-network providers works:

You broke your arm while covered under Company A's health plan and saw a Company A network doctor to set your arm. You changed health plans and are now covered under Company B's plan. Your doctor is not a network provider with Company B. You now need to have the cast removed and want to see the original doctor who put on the cast.

In this example, you or your representative needs to contact Company B so that Company B can pay your claim as if you are still receiving care from a network doctor. If the non-network doctor accepts Company B's rate of payment, the doctor is only permitted to bill you for the in-network cost-sharing amounts that apply to the service, such as copayments, coinsurance and deductible. In this example, if the non-network doctor will *not* accept Company B's rate of payment, the doctor may decide *not* to provide services to you, or may continue to provide services to you and bill you not only for any copayment, coinsurance or deductible that applies, but also bill you for the difference between the doctor's fee and the allowable charge determined by Company B.

Appeal Rights: If we deny your right to use a prior approval from your old company or your right to continue to see a provider who was an in-network provider with your old company, you may appeal this denial by contacting us at:

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

If we deny your appeal, you may file a complaint with the Maryland Insurance Administration. To receive a complaint form from the Maryland Insurance Administration call 1-800-492-6116, select option 3, then option 2 or download a complaint form from the Maryland Insurance Administration's website at www.mdinsurance.state.md.us.

If you have any questions about this notice, please contact us at the phone number on the back of your ID.

HC-IMP215 01-16

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 by mail or fax to the claims address or fax number listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by calling Member Services using the toll-free number on your identification card. If Cigna does not provide you claim forms within 15 days after your notice of claim is received, you are considered to have complied with the requirements of the policy, as to proof of loss, if you submit – within the time period described in the "Timely Filing of Claims" provision below – written proof of the occurrence, character and extent of the loss for which the claim is made.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

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

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 365 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service.

Failure to submit a claim for Out-of-Network benefits after the date of service does not invalidate or reduce the amount of the claim if it was not reasonably possible to submit the claim within 1 year after the date of service; and the claim is submitted within 2 years after the date of service. If the claimant is legally incapacitated, the deadline to submit a claim is suspended until legal capacity is regained.

Statements Not Warranties

All statements made by you will, in the absence of fraud, be deemed representations and not warranties. No statement made by you to obtain insurance will be used to avoid the insurance or reduce benefits under the policy after your insurance has been in force for a period of two years during your lifetime. Additionally, no such statement will be used to avoid the insurance or reduce benefits under the policy unless the statement was material to the risk assumed, and unless the statement was made in writing and signed by you, and unless a copy of it is sent to you or your Beneficiary.

WARNING: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

HC-CLM121 12-17

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 40 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

The first day of the month following 30 days after date of hire.

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 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 again elect it after you cancel your payroll deduction (if required).

Exception for Certain Dependent Children

Any Dependent child:

- born; or
- newly adopted; or
- newly granted to your guardianship by a court or testamentary appointment while you are insured will become insured on such date of birth, adoption, or appointment, as applicable.

If a premium contribution is required for you to add such child to your Dependent Insurance, you must elect to insure the child within 31 days after the date of the birth, adoption or appointment as applicable, in order to continue the child's coverage after the end of that 31-day period. If your Dependent Insurance for the child ends at the end of that 31-day period, no benefits for expenses incurred after the 31st day will be payable.

Any Dependent child(ren) who were covered as dependents under your spouse's group health insurance certificate, on the date of your spouse's death, may be added as Dependents to your Medical Insurance under this plan at any time and without evidence of good health. To do so, you must elect the Dependent Insurance within 6 months after the date of your spouse's death.

This provision applies regardless of whether the Dependent child(ren) are eligible for any continuation or conversion privileges under the spouse's group health insurance certificate.

Exception for Certain Spouses and Children

If you are married, and your spouse and/or children are covered under the spouse's group health insurance certificate on the date the spouse loses coverage under that certificate because of the involuntary termination of the spouse's employment other than for cause, then you may add your spouse and/or children to your Medical Insurance under this plan without evidence of good health. To do so, you must notify the Policyholder and elect the Dependent Insurance within 6 months after the date on which the spouse's prior group health insurance coverage terminates.

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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.

Referral For Services by a Non-Participating Specialist or Nonphysician Specialist

You may receive a referral to a non-participating specialist or nonphysician specialist if: you are diagnosed with a condition or disease that requires specialized health care services or medical care; we do not have a participating specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or we cannot provide reasonable access to a specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel. Any deductible, copayment or coinsurance applicable to the services for which the referral is requested will be calculated as if the services were received from a Participating Provider.

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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 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. However for the purposes of this Schedule, the percentage an insured person is required to pay equals the difference between 100% and the percentage that is paid by Cigna as shown in the following Benefit Highlights pages.

Deductibles

Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance.

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 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.

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 benefit deductibles.
- Provider charges in excess of the Maximum Reimbursable Charge.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums will cross-accumulate (that is, In-Network will accumulate to Out-of-Network and Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) also cross-accumulate between In- and Out-of-Network unless otherwise noted.

Note:
For information about your health fund benefit and how it can help you pay for expenses that may not be covered under this plan, refer to “What You Should Know about Cigna Choice Fund”.

Open Access Plus Medical Benefits

The Schedule

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.

Out-of-Network Emergency Services Charges

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

   For certain facilities located in Maryland, the allowable amount may be determined by the Maryland Health Services Cost Review Commission (HSCRC).
   For covered services rendered by an Out-of-Network on-call or Hospital-based Physician who is licensed in Maryland, the allowable amount may be determined as indicated in General Reimbursement Information within the Maximum Reimbursable Charge definition.
   The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance).
   The member is also responsible for all charges that may be made in excess of the allowable amount, except as indicated in General Reimbursement Information within the Maximum Reimbursable Charge definition. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

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.	90%	80% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maximum Reimbursable Charge In no event will Cigna's allowed amount paid to a non-Participating Provider for a covered health care service be less than the allowed amount paid to a similarly licensed provider who is a Participating Provider, for the same service in the same geographical region. Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or		
A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database Cigna has selected. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. **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 and coinsurance.	Not Applicable	80th Percentile

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
Individual	$1,400 per person	$2,800 per person
Family Maximum	$2,800 per family	$5,600 per family
Family Maximum Calculation **Collective Deductible:** All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.		
Combined Medical/Pharmacy Calendar Year Deductible		
Combined Medical/Pharmacy Deductible: includes retail and home delivery drugs	Yes	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Deductible	Yes	Yes
Out-of-Pocket Maximum		
Individual	$2,500 per person	$5,000 per person
Family Maximum	$5,000 per family	$9,600 per family
Family Maximum Calculation **Collective Out-of-Pocket Maximum:** All family members contribute towards the family Out-of-Pocket. An individual cannot have claims covered at 100% until the total family Out-of-Pocket has been satisfied.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Combined Medical/Pharmacy Out-of-Pocket Maximum		
Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery drugs	Yes	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	Yes	Yes
Physician's Services		
Primary Care Physician's Office Visit	90% after plan deductible	80% after plan deductible
Specialty Care Physician's Office Visits	90% after plan deductible	80% after plan deductible
Consultant and Referral Physician's Services		
Surgery Performed in the Physician's Office	90% after plan deductible	80% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	90% after plan deductible	80% after plan deductible
Allergy Treatment/Injections	90% after plan deductible	80% after plan deductible
Allergy Serum (dispensed by the Physician in the office)	90% after plan deductible	80% after plan deductible
Preventive Care		
Routine Preventive Care (through age 16)	No charge	80%
Routine Preventive Care (age 17 and over)	No charge	80% after plan deductible
Immunizations (through age 16)	No charge	80%
Immunizations (age 17 and over)	No charge	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mammograms		
Preventive Care Related Services (i.e. "routine" services)	No charge	80%
Diagnostic Related Services (i.e. "non-routine" services)	90% after plan deductible	80% after plan deductible
PSA, PAP Smear and Mandated Screening Tests Screenings include: • Prostate Cancer including a digital rectal exam and PSA • Colorectal Cancer • Breast Cancer • Osteoporosis prevention and treatment including bone mass measurement • Chlamydia and Human Papillomavirus (HPV)		
Preventive Care Related Services (i.e. "routine" services)	No charge	80% after plan deductible
Diagnostic Related Services (i.e. "non-routine" services)	90% after plan deductible	80% after plan deductible
Inpatient Hospital - Facility Services	90% after plan deductible	80% after plan deductible
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room and when provided instead of an inpatient service, when an attending physician's request for an inpatient admission has been denied.	90% after plan deductible	80% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	90% after plan deductible	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	90% after plan deductible	80% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	90% after plan deductible	80% after plan deductible
Urgent Care Services		
Physician's Office Visit	90% after plan deductible	Same as In-Network
Urgent Care Facility or Outpatient Facility	90% after plan deductible	Same as In-Network
Outpatient Professional Services (radiology, pathology, physician)	90% after plan deductible	Same as In-Network
X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit)	90% after plan deductible	Same as In-Network
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	90% after plan deductible	Same as In-Network
Emergency Services		
Physician's Office Visit	90% after plan deductible	Same as In-Network
Hospital Emergency Room	90% after plan deductible	Same as In-Network
Outpatient Professional Services (radiology, pathology, ER physician)	90% after plan deductible	Same as In-Network
X-ray and/or Lab performed at the Emergency Room Facility (billed by the facility as part of the ER visit)	90% after plan deductible	Same as In-Network
Independent X-ray and/or Lab Facility in conjunction with an ER visit	90% after plan deductible	Same as In-Network
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	90% after plan deductible	Same as In-Network
Ambulance	90% after plan deductible	Same as In-Network

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 60 days combined	90% after plan deductible	80% after plan deductible
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office Visit	90% after plan deductible	80% after plan deductible
Outpatient Hospital Facility	90% after plan deductible	80% after plan deductible
Independent X-ray and/or Lab Facility	90% after plan deductible	80% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Physician's Office Visit	90% after plan deductible	80% after plan deductible
Inpatient Facility	90% after plan deductible	80% after plan deductible
Outpatient Facility	90% after plan deductible	80% after plan deductible
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: 90 days for all therapies combined (The limit is not applicable to mental health conditions.) Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	90% after plan deductible	80% after plan deductible
Habilitative Services and Devices Habilitative Services and Devices for Dependent children under 19 who need to keep, learn or improve skills and enhance functioning for daily living, until the end of the month in which the child turns age 19. Calendar Year Maximum: Unlimited		
Chiropractic Care Calendar Year Maximum: 24 days		
Physician's Office Visit	90% after plan deductible	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Home Health Care Calendar Year Maximum: 60 days (includes outpatient private nursing when approved as Medically Necessary)	90% after plan deductible	80% after plan deductible
Home Visits - Mastectomy or Surgical Removal of a Testicle Calendar Year Maximum: One visit within 24 hours after discharge from the Hospital or outpatient health facility; one additional visit when approved by the attending Physician for an outpatient procedure or for an inpatient stay of less than 48 hours.		
Hospice		
Inpatient Services	90% after plan deductible	80% after plan deductible
Outpatient Services (same coinsurance level as Home Health Care)	90% after plan deductible	80% after plan deductible
Bereavement Counseling		
Services provided as part of Hospice Care		
Inpatient	90% after plan deductible	80% after plan deductible
Outpatient	90% after plan deductible	80% after plan deductible
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Maternity Care Services		
Initial Visit to Confirm Pregnancy	90% after plan deductible	80% after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	90% after plan deductible	80% after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	90% after plan deductible	80% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center) **Note:** Benefit levels will be the same as the benefit levels for Inpatient Hospital Facility Services for any other covered Sickness.	90% after plan deductible	80% after plan deductible
Home Visits, as required by law and as recommended by the Physician	No charge	No charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Abortion Includes elective and non-elective procedures		
Physician's Office Visit	90% after plan deductible	80% after plan deductible
Inpatient Facility	90% after plan deductible	80% after plan deductible
Outpatient Facility	90% after plan deductible	80% after plan deductible
Physician's Services	90% after plan deductible	80% after plan deductible
Women's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	No charge	80% after plan deductible
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.		
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)		
Physician's Office Visit	No charge	80% after plan deductible
Inpatient Facility	No charge	80% after plan deductible
Outpatient Facility	No charge	80% after plan deductible
Physician's Services	No charge	80% after plan deductible
Men's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	No charge	80% after plan deductible
Surgical Sterilization Procedures for Vasectomy (excludes reversals)		
Physician's Office Visit	No charge	80% after plan deductible
Inpatient Facility	No charge	80% after plan deductible
Outpatient Facility	No charge	80% after plan deductible
Physician's Services	No charge	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • 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 Insemination, In-vitro, GIFT, ZIFT, etc. Lifetime Maximum for Outpatient in-vitro fertilization: Unlimited per lifetime. Up to 3 attempts per live birth. Outpatient in-vitro fertilization benefit levels will be the same as the benefit levels for any other pregnancy-related procedures. Services Not Covered: Refer to the Covered Expenses, Infertility Services provision of your certificate. **Note:** For services other than Outpatient in-vitro fertilization services, benefit levels will be the same as for any other covered Sickness.		
Physician's Office Visit (Lab and Radiology Tests, Counseling)	90% after plan deductible	80% after plan deductible
Inpatient Facility	90% after plan deductible	80% after plan deductible
Outpatient Facility	90% after plan deductible	80% after plan deductible
Physician's Services	90% after plan deductible	80% after plan deductible
Fertility Awareness-Based Methods Instruction	No charge	No charge
Organ Transplants Includes all medically appropriate, non-experimental transplants Calendar Year Maximum for all Out-of-Network benefits for Organ Transplants: $75,000		
Physician's Office Visit	90% after plan deductible	80% after plan deductible
Inpatient Facility	100% at LifeSOURCE center after plan deductible, otherwise 90% after plan deductible	80% after plan deductible
Physician's Services	100% at LifeSOURCE center after plan deductible, otherwise 90% after plan deductible	80% after plan deductible
Durable Medical Equipment Calendar Year Maximum: Unlimited	90% after plan deductible	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
External Prosthetic Appliances Calendar Year Maximum: Unlimited **Note:** For EPAs meant to replace, in whole or in part, an arm, a leg or an eye: benefit levels will be the same as the benefit levels for primary care benefits covered under the policy.	90% after plan deductible	80% after plan deductible
Hearing Aids (Includes testing and fitting of hearing aid devices) Maximum: Unlimited per ear every 36 months	90% after plan deductible	80% after plan deductible
Diabetic Equipment Calendar Year Maximum: Unlimited	90% after plan deductible	80% after plan deductible
Nutritional Evaluation Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of diabetes and/or to mental health and substance use disorder conditions.		
Physician's Office Visit	90% after plan deductible	80% after plan deductible
Inpatient Facility	90% after plan deductible	80% after plan deductible
Outpatient Facility	90% after plan deductible	80% after plan deductible
Physician's Services	90% after plan deductible	80% after plan deductible
Genetic Counseling Calendar Year Maximum: 3 visits per person for Genetic Counseling for both pre- and post-genetic testing; however, the 3 visit limit will not apply to Mental Health and Substance Use Disorder conditions.		
Physician's Office Visit	90% after plan deductible	80% after plan deductible
Inpatient Facility	90% after plan deductible	80% after plan deductible
Outpatient Facility	90% after plan deductible	80% after plan deductible
Physician's Services	90% after plan deductible	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to teeth.		
Physician's Office Visit	90% after plan deductible	80% after plan deductible
Inpatient Facility	90% after plan deductible	80% after plan deductible
Outpatient Facility	90% after plan deductible	80% after plan deductible
Physician's Services	90% after plan deductible	80% after plan deductible
TMJ Surgical and Non-Surgical Always excludes appliances and orthodontic treatment. Subject to medical necessity. **Note:** Benefit levels will be the same as the benefit levels for any other covered condition, based on the type and location of service provided.		
Physician's Office Visit	90% after plan deductible	80% after plan deductible
Inpatient Facility	90% after plan deductible	80% after plan deductible
Outpatient Facility	90% after plan deductible	80% after plan deductible
Physician's Services	90% after plan deductible	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Breast Reduction When medically necessary	90% after plan deductible	80% after plan deductible
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.
Additional Benefits and Provisions Calendar Year Maximum: Unlimited Includes: • Treatment of Morbid Obesity. • Cleft Lip/Cleft Palate Services. • Breast Reconstruction Surgery, including physical complications of all stages of mastectomy, including lymphedemas in a manner determined in consultation with the attending Physician and the patient. • Breast Prostheses. • Blood Products. • Medical Foods and Low Protein Food Products. • Amino Acid-Based Elemental Formula. • Diabetes Equipment, Supplies and Training. • Clinical Trials. • Dental Care (Anesthesia and Facility Charges). • Telehealth. **Note:** Benefit levels for these additional benefits are subject to the same cost-sharing requirements as for any other similar covered service, depending on the type and place of the service provided.		
Physician's Office Visit	90% after plan deductible	80% after plan deductible
Inpatient Facility	90% after plan deductible	80% after plan deductible
Outpatient Facility	90% after plan deductible	80% after plan deductible
Physician's Services	90% after plan deductible	80% after plan deductible
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health		
Inpatient Includes Acute Inpatient and Residential Crisis Treatment Calendar Year Maximum: Unlimited	90% after plan deductible	80% after plan deductible
Outpatient		
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, etc. Calendar Year Maximum: Unlimited	90% after plan deductible	80% after plan deductible
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, Applied Behavioral Analysis, etc. Calendar Year Maximum: Unlimited	90% after plan deductible	80% after plan deductible
Substance Use Disorder		
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Crisis Treatment Calendar Year Maximum: Unlimited	90% after plan deductible	80% after plan deductible
Outpatient		
Outpatient - Office Visits	90% after plan deductible	80% after plan deductible
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, etc. Calendar Year Maximum: Unlimited	90% after plan deductible	80% 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 Use Disorder;
- for Mental Health or Substance Use Disorder Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. The Review Organization will make all initial determinations on whether to authorize or certify a non-emergency course of treatment within two working days of receipt of the information necessary to make their decision; and promptly notify the attending health care provider and patient of that determination. If the Review Organization does not have sufficient information to make a determination within three calendar days of the initial request for health care services, the Review Organization will notify the health care provider that additional information must be provided. For an inpatient or residential crisis services admission for the treatment of a mental, emotional, or substance use disorder, the Review Organization will make all determinations on whether to authorize or certify an inpatient admission or an admission for residential crisis services within two hours after receipt of the information necessary to make the determination, and promptly notify the health care provider of that determination.

Written notice of an adverse decision will be sent to you and to the attending health care provider within five working days after the adverse decision has been made.

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, by the end of the first scheduled work day after the date of admission, or as soon as reasonably possible.

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.

All determinations for an extended stay in a health care facility or additional health care services will be made within one working day of receipt of the information necessary to make that determination. The attending health care provider will be notified promptly of the determination.

In the case of an emergency admission, you should contact the Review Organization by the end of the first scheduled work day after the admission or as soon as reasonably possible. The Review Organization will not render an adverse decision for an emergency admission solely because the Hospital did not notify the Review Organization of the emergency admission within 24 hours or by the end of the first scheduled work day after the admission if the patient's medical condition prevented the Hospital from determining the patient's insurance status and the Review Organization's emergency admission notification requirements. The Review Organization will not render an adverse decision during the first 24 hours after a patient's admission when: the admission is based on a determination that the patient is in imminent danger to self or others; the determination was made by the patient's Physician or Psychologist in conjunction with a member of the facility's medical staff; and the facility immediately notifies the Review Organization of the patient's admission and the reasons for the admission. The Review Organization will not render an adverse decision for up to 72 hours for a Hospital admission determined to be Medically Necessary for the patient's treating Physician when: the admission is an involuntary psychiatric admission; and the Hospital immediately notifies the Review Organization of the patient's admission and the reasons for the admission. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

In the case of an admission due to pregnancy, a call by you to the Review Organization prior to the end of the third month of pregnancy will allow the Review Organization an opportunity to obtain information from you that could determine whether a referral to Cigna's maternity-related case management programs is indicated.

If there is an adverse determination in regard to any of the above determinations, the Review Organization will provide

an opportunity for the health care provider to seek a reconsideration by telephone on an expedited basis not to exceed 24 hours.

If a course of treatment has been preauthorized or approved for a patient, the Review Organization will not retrospectively render an adverse decision regarding the preauthorized or approved services delivered to the patient.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted. A representative of the Review Organization is reasonably accessible to patients and health care providers in Maryland 7 days a week, 24 hours a day.

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.

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V1

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;
- non-emergency ambulance; or
- transplant services.

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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 for an outpatient service provided instead of an inpatient service, when an attending Physician's request for an inpatient admission is denied after utilization review has been conducted.
- charges for an objective second opinion, when required by a utilization review program.
- 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 breast cancer screenings in accordance with the latest screening guidelines issued by the American Cancer Society, including coverage for digital tomosynthesis, that the treating provider determines to be Medically Necessary. Digital tomosynthesis means a radiologic procedure that involves that acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the

breast. Coverage will not be provided for breast cancer screenings used to identify breast cancer in asymptomatic women when the screenings are provided by a facility that is not accredited by the American College of Radiology or certified or licensed under a program established by the State of Maryland. A Deductible will not apply to this benefit.

- charges for or in connection with a diagnostic exam for prostate cancer including a digital rectal exam and a prostate-specific antigen (PSA) test: for men who are between 40 and 75 years of age; when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; when used for staging in determining the need for a bone scan in patients with prostate cancer; or when used for male patients who are at high risk for prostate cancer.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges made for the following preventive care services (detailed information is available at www.healthcare.gov.):
  (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. (however, such recommendations issued in or around November 2009, with respect to breast cancer screenings, mammography and prevention, are not considered to be current);
  (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.

  Cigna will update the terms of this provision to reflect new recommendations to the preventive care services described herein at the schedule established by the Secretary of Health and Human Services.

In addition, Covered Expenses will include expenses incurred for a Dependent child for charges made for Child Preventive Care Services consisting of the following services, delivered or supervised by a Physician, in keeping with prevailing medical standards:

- all visits for and costs of childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control including charges for physical examinations, development assessments and parental anticipatory guidance provided in conjunction with these services;
- all visits prior to 4 weeks of age for hereditary and metabolic disease screening (the first screening sample is to be collected before 2 weeks of age) including charges for physical examinations, development assessments and parental anticipatory guidance provided in conjunction with these services;
- all visits for obesity evaluation and management including charges for physical examinations, development assessments and parental anticipatory guidance provided in conjunction with these services;
- all visits for and costs of developmental screenings as recommended by the American Academy of Pediatrics including charges for physical examinations, development assessments and parental anticipatory guidance provided in conjunction with these services;
- all visits for and costs of age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing and vision as determined by the American Academy of Pediatrics including charges for physical examinations, development assessments and parental anticipatory guidance provided in conjunction with these services;
- universal hearing screening of newborns provided by a Hospital before discharge;
- laboratory tests considered necessary by the Physician and provided in conjunction with the above services;

excluding any charges for:

- services for which benefits are otherwise provided under this Covered Expenses section;
- services for which benefits are not payable according to the Expenses Not Covered section.

A Deductible will not apply to the Child Preventive Care benefit.

- charges made for inpatient hospitalization services for a mother and newborn child for a minimum of: 48 hours on inpatient hospitalization care after an uncomplicated vaginal delivery; and 96 hours of inpatient hospitalization care after an uncomplicated cesarean section. A mother may request a shorter length of stay than that provided if the mother

decides, in consultation with her attending provider, that less time is needed for recovery.

If the mother and newborn child have a shorter Hospital stay than that provided, coverage is provided for: (a) one home visit scheduled to occur within 24 hours after Hospital discharge; and (b) an additional home visit if prescribed by the attending provider. The home visit must: (a) be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child; (b) be provided by a registered Nurse with at least one year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and (c) include any services required by the attending provider.

If the mother and newborn child remain in the Hospital for at least the minimum length of time provided, coverage is provided for a home visit if prescribed by the attending provider. The home visit must: (a) be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child; (b) be provided by a registered Nurse with at least one year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and (c) include any services required by the attending provider.

Additionally, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn also remain in the Hospital, coverage will be provided for additional hospitalization for the newborn for up to four days.

- charges for inpatient or outpatient expenses for orthodontics; oral surgery; and otological, audiological and speech/language treatment involved in the management of cleft lip or cleft palate or both.
- charges for covered services provided to an insured person by a community health resource. A community health resource means a nonprofit or for profit health care center or program that offers the primary health care services required by the Maryland Community Health Resources Commission on a sliding fee schedule and without regard to an individual's ability to pay. A community health resource includes: a federally qualified health center; a federally qualified health center "look-alike"; a community health center; a migrant health center; a health care program for the homeless; a primary care program for a public housing project; a local nonprofit and community-owned health care program; a school-based health center; a teaching clinic; a well mobile; a health center controlled operating network; a historic Maryland primary care provider; an outpatient mental health clinic; and any other center or program identified by the Maryland Community Health Resources Commission as a community health resource.
- charges made for testing of bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis when the bone mass measurement is requested by a health care provider for a qualified individual. A "qualified individual" means: an estrogen-deficient individual at clinical risk for osteoporosis; an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease; an individual receiving long-term glucocorticoid (steroid) therapy; an individual with primary hyperparathyroidism; or an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
- charges for a drug that has been prescribed for a use for which it has not been approved by the Food and Drug Administration (FDA). Such a drug must be covered, provided: the drug must be recognized for the use prescribed in any one of the following established reference compendia (that is, any authoritative compendia as recognized periodically by the federal Secretary of Health and Human Services or the Maryland Insurance Commissioner); or any national peer-reviewed professional medical journal; the drug has been otherwise approved by the FDA; and the drug has not been contraindicated by the FDA for the off-label use prescribed.
- charges for an annual routine chlamydia screening test for: women who are under age 20 if they are sexually active; women who are at least age 20 if they have multiple risk factors; and men who have multiple risk factors.

  Chlamydia screening means any lab test approved by the FDA that specifically detects infection by one or more agents of chlamydia trachomatis. Multiple risk factors means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives or cervical ectopy.
- charges for a human papillomavirus screening at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists.

  Human papillomavirus screening test means any laboratory test that: specifically detects for infection by one or more agents of the human papillomavirus; and is approved for this purpose by the FDA.
- charges for one hair prosthesis when prescribed by an oncologist for hair loss suffered as a result of chemotherapy or radiation treatment for cancer.
- coverage of Habilitative Services for children,, as defined, including those that are Medically Necessary and

appropriate to treat autism and autism spectrum disorders, until the end of the month in which the child turns 19 years old. Coverage is not provided for Habilitative Services delivered through early intervention or school services.

- charges made by a Hospital or Ambulatory Surgical Facility for anesthesia and facility charges for dental procedures for: a covered person age 7 or under or a covered person who is developmentally disabled for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition and for whom a superior result can be expected from dental care provided under general anesthesia; or a covered person who is an extremely uncooperative, fearful, or uncommunicative child age 17 or under with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.
- charges for hearing aids provided the hearing aids are prescribed, fitted and dispensed by a licensed audiologist. Hearing aid means a device that: is of a design and circuitry to optimize audibility and listening skills in the environment and is non-disposable.
- charges for colorectal cancer screening in accordance with the latest American Cancer Society guidelines.
- charges for inpatient hospitalization services for a minimum of 48 hours following a mastectomy. Mastectomy means the surgical removal of all or part of a breast as a result of diseased breast. A patient may request a shorter length of stay if the patient decides, in consultation with the patient's attending Physician, that less time is needed for recovery.
- charges for one home visit for a patient who remains in the Hospital for at least 48 hours following a mastectomy, if prescribed by the attending Physician.
- for a patient who remains in the Hospital for less than 48 hours following a mastectomy, or who undergoes a mastectomy on an outpatient basis: charges for: one home visit, scheduled to occur within 24 hours after discharge from the Hospital or outpatient health care facility; and an additional home visit if prescribed by the patient's attending Physician.
- for a patient who remains in the Hospital for less than 48 hours following surgical removal of a testicle, or who undergoes surgical removal of a testicle on an outpatient basis: charges for: one home visit, scheduled to occur within 24 hours after discharge from the Hospital or outpatient health care facility; and an additional home visit if prescribed by the patient's attending Physician.
- charges for all medically appropriate and necessary diabetes equipment, diabetes supplies, and diabetes outpatient self-management training and educational services, including medical nutrition therapy, that the covered person's treating Physician or other appropriately licensed health care provider, or a Physician who specializes in the treatment of diabetes, certifies are necessary for the treatment of: (a) insulin-using diabetes; (b) noninsulin-using diabetes; (c) elevated or impaired blood glucose levels induced by pregnancy; or (d) elevated or impaired blood glucose levels induced by pre-diabetes. If certified as necessary, the diabetes self-management training and educational services, including medical nutrition therapy, shall be provided through a program supervised by an appropriately licensed, registered or certified health care provider whose scope of practice includes diabetes education or management.
- charges for the diagnostic or surgical procedures involving a bone or joint of the face, neck or head if, under the accepted standards of the profession of the health care provider rendering the service, the procedure is Medically Necessary to treat a condition caused by a congenital deformity, disease or Injury.
- coverage for Medically Necessary and appropriate equipment and supplies used to treat ostomies, including: flanges, collection bags, clamps, irrigation devices, sanitizing product, ostomy rings, ostomy belts and catheters used for drainage of urostomies.
- coverage for the Medically Necessary diagnosis, evaluation, and treatment of lymphedema, including equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education.

  Gradient Compression Garment means a garment that:

  - Is used for the treatment of lymphedema;
  - Requires a prescription; and
  - Is custom fit for the individual for whom the garment is prescribed.

  Gradient Compression Garment does not include disposable medical supplies, including over-the-counter compression or elastic knee-high or other stocking products.
- charges for acupuncture.

Clinical Trials

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

(a) is eligible as a result of treatment provided for a life-threatening disease or condition or prevention, early detection, and treatment studies on cancer; 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).

The clinical trial must meet the following requirements:

- treatment is being provided or the studies are being conducted in a phase I, phase II, phase III, or phase IV clinical trial for cancer;
- treatment is being provided in a phase I, phase II, phase III, or phase IV clinical trial for any other life-threatening condition;
- treatment is being provided in a clinical trial approved by:
  - one of the National Institutes of Health (NIH);
  - an NIH cooperative group or an NIH center;
  - the FDA in the form of an investigational new drug application;
  - the federal department of veterans affairs; or
  - an institutional review board of an institution in the state that has a multiple project assurance contract approved by the office of protection from research risks of the NIH.

Coverage shall be provided for routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

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.

Routine patient care cost is defined as the cost of a Medically Necessary 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 that is incurred as a result of the treatment being provided to the member for purposes of the clinical trial.

Routine patient care costs do not include:

- the cost of an investigational drug or device;
- the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for the purposes of the clinical trial;
- costs associated with managing the research associated with the clinical trial; or
- costs that would not be covered under the patient's policy, plan or contract for non-investigational treatments.

If your plan includes In-Network providers, Clinical trials conducted by non-Participating Providers will be covered at the In-Network benefit level if:

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

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

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

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

Nutritional Evaluation and Counseling

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

Nutritional Products

Coverage is provided for medical foods and low protein modified food products, for the treatment of inherited metabolic diseases, provided the foods/products are: prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic diseases; and administered under the direction of a Physician. An inherited metabolic disease is a disease caused by an inherited abnormality of body chemistry, including a disease for which the state screens newborns. A medical food is a food intended for the dietary treatment of a disease/condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the

direction of a Physician. A low protein modified food product is a food product specially formulated to have less than one gram of protein per serving, and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease. Low protein modified food products do not include natural foods that are naturally low in protein.

Coverage also includes amino acid-based elemental formula, regardless of delivery method, for the diagnosis and treatment of: Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorder, as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract. The ordering Physician must issue an order stating that the treatment is Medically Necessary.

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.

Private Hospital Rooms

Charges for private rooms as determined by the Health Services Cost Review Commission, but not beyond those rates.

Fertility Awareness-Based Methods

- charges for instruction by a licensed health care provider on Fertility Awareness-Based Methods.

  Fertility Awareness-Based Methods means methods of identifying times of fertility and infertility by an individual to avoid pregnancy, including:

  - cervical mucus methods;
  - symptom-thermal or symptom-hormonal methods;
  - the standard days method; and
  - the lactational amenorrhea method.

Fertility Preservation Procedures

- Coverage will be provided for Standard Fertility Preservation Procedures:
  - performed on a Policyholder or subscriber or on the covered Dependent of a Policyholder or subscriber; and
  - that are Medically Necessary to preserve fertility for a Policyholder or subscriber or for the covered Dependent of a Policyholder or subscriber due to a need for medical treatment that may directly or indirectly cause Iatrogenic Infertility.
    - Iatrogenic Infertility means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or processes.
    - Medical Treatment that may directly or indirectly cause Iatrogenic Infertility means medical treatment with a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.
    - Standard Fertility Preservation Procedures means procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.
    - Standard Fertility Preservation Procedures includes sperm and oocyte cryopreservation and evaluations, laboratory assessments, medications, and treatments associated with sperm and oocyte cryopreservation.

In Vitro Fertilization (IVF)

Coverage will be provided for outpatient expenses arising from in vitro fertilization procedures if:

- you are the Employee or a covered Dependent of the Employee;
- for a patient whose spouse is of the opposite-sex, the patient's oocytes are fertilized with the patient's spouse's sperm unless:

  The patient’s spouse is unable to produce and deliver functional sperm; and the inability to produce and deliver functional sperm does not result from a vasectomy; or another method of voluntary sterilization.
- the patient or the patient’s spouse have a history of involuntary infertility which may have been demonstrated by a history of:
  - If the patient and the patient’s spouse are of opposite sexes, intercourse of at least 2 years duration failing to result in pregnancy; or
  - If the patient and the patient’s spouse are the same sex, six attempts of artificial insemination over the course of 2 years failing to result in pregnancy; or the infertility is associated with any of the following medical conditions:
    - endometriosis;

- exposure in utero to diethylstilbestrol (DES);
- blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
- abnormal male factors, including oligospermia, contributing to the infertility;
- the patient has been unable to attain successful pregnancy through a less costly infertility treatment for which coverage is available under this plan; and
- the in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimum standards for programs of in vitro fertilization or the American Society for Reproductive Medicine.

Telehealth

Coverage will be provided for Covered Expenses, including counseling for substance use disorders that can be appropriately provided through Telehealth, subject to a maximum benefit shown in The Schedule, if applicable and permitted by federal law.

"Telehealth" means the use of interactive audio, video, or other telecommunications or electronic technology by a licensed Physician to deliver Covered Expenses that are within the scope of practice of the Physician at a site other than the site at which the patient is located.

It does not include an audio-only telephone conversation, and electronic mail message, or a facsimile transmission between a Physician and covered person.

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Obesity Treatment

- charges for the surgical treatment of morbid obesity that is: recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity; and consistent with criteria approved by the National Institutes of Health. Morbid Obesity means a body mass index that is greater than 40 kilograms per meter squared, or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes. Body mass index means a practical marker that is issued to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

HC-COV30 04-10
V1

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 performed 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-COV31 04-10
V1

Home Health Services

- charges made for Home Health Services if: institutionalization would have been required if home health was not provided; and your Physician establishes and approves in writing the plan of treatment covering the home health care service. Home Health Services are subject to the benefit limitations described here and the visit limitations shown in The Schedule. A visit is defined as a period of 4 hours or less. Home Health Services may include the services of a home health aide if the services of the aide are rendered in direct support of skilled health care that is being provided by Other Participating Health Professionals.

  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 non-skilled 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 non-skilled care and/or custodial services needs.

  Home Health Services shall be provided by: a Hospital that has a valid operating certificate and is certified to provide home health care services; or a public or private health service or agency that is licensed as a home health agency under Title 19, Subtitle 4 of the Health – General Article to provide coordinated home health care. Necessary consumable medical supplies, home infusion therapy, administered or used by: a Hospital that has a valid

operating certificate and is certified to provide home health care services; or a public or private health service or agency that is licensed as a home health agency under Title 19, Subtitle 4 of the Health – General Article to provide coordinated home health care 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 professional. 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 and Chiropractic Care Services in The Schedule.

HC-COV477 01-16
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, including a family caregiver;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including a family caregiver, for bereavement counseling sessions for the six-month period following the person's death or 15 counseling sessions, whichever occurs first;
  - for dietary counseling for the terminally ill insured;
  - for comfort maintenance and pain relief treatment, including drugs, medicines and medical supplies and equipment;
  - for Respite Care for the caregiver not to exceed 14 days per contract year, which is the 12-month period that begins with the effective date of the policy;
  - for part-time or intermittent nursing care by or under the supervision of a Nurse;
  - for 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 spouse, parent, sibling, grandparent, or children of the terminally ill insured or services of one 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-COV33 04-10
V1

Mental Health and Substance Use Disorder Services

Mental Health Services are Medically Necessary services that are required to treat a mental illness or emotional disorder. 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. Physiological conditions related to Mental Health will be covered as any other illness through the medical/surgical benefits section of the plan.

Substance Use Disorder is defined as Alcohol Misuse or Drug Misuse 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 misuse will not be considered to be charges made for treatment of Substance Use Disorder. Physiological conditions related to Substance Use Disorder will be covered as any other illness through the medical/surgical benefits section of the plan.

Alcohol Misuse means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial or psycho-social.

Detoxification facility means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill

the physical, social, and emotional needs of the individual by: monitoring the amount of alcohol and other toxic agents in the body of the individual; managing withdrawal symptoms; and motivating the individual to participate in the appropriate addictions treatment programs for alcohol or drug abuse.

Drug means a controlled dangerous substance that is regulated under the Maryland Controlled Dangerous Substances Act; a prescription medication; or a chemical substance when used for unintended and harmful purposes.

Drug Misuse means a disease which is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Partial Hospitalization means the provision of medically directed intensive or intermediate short-term treatment: to a customer; in a licensed or certified facility or program; for mental illness, emotional disorders, drug misuse, or alcohol misuse; and for a period of less than twenty-four (24) hours but more than four (4) hours in a day.

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 Crisis Services. These inpatient services are provided for an unlimited number of days per year under the same terms and conditions that apply to physical illness.

Mental Health Residential Crisis Services means intensive mental health and support services that are:

- provided to a child or an adult with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the individual's ability to function in the community;
- designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;
- provided out of the individual's residence on a short-term basis in a community-based residential setting; and
- provided by entities that are licensed by the Department of Health and Mental Hygiene to provide residential crisis services.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient or Out-of-Hospital basis, while you or your Dependent is not Confined in a Hospital, in an individual or 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 and for psychological and neuropsychological testing for diagnosis purposes.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program in accordance with the laws of the appropriate, legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy. A physician's recommendation that an Intensive Outpatient Program is the best mode of treatment for an individual will not affect the availability of Inpatient Mental Health Services and regular Outpatient Mental Health Services for which the individual would otherwise be eligible.

Coverage is provided for a diagnostic evaluation, psychological and neuropsychological testing for diagnostic purposes, opioid treatment services; and medication evaluation and management visits provided to treat mental illnesses, emotional disorders, drug misuse, or alcohol misuse.

Services will be provided under the same terms and conditions that apply to an office visit for physical illness.

Inpatient Substance Use Disorder Rehabilitation Services

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

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

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

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

Outpatient Substance Use Disorder Rehabilitation Services

Services provided for the diagnosis and treatment of misuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Use Disorder Partial Hospitalization, or Intensive Outpatient Therapy Program, including diagnostic evaluation; psychological or neuropsychological testing for diagnosis purposes; opioid treatment services; and medication evaluation and management visits.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy. A physician's recommendation that an Intensive Outpatient Program is the best mode of treatment for an individual will not affect the availability of Inpatient Substance Use Disorder Services and regular Outpatient Substance Use Disorder Services for which the individual would otherwise be eligible.

Substance Use Disorder Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs.

Exclusions

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

- treatment of medical disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain; provided, however, that such treatment be covered under the medical benefit provision of this plan.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders, unless such developmental disorder is treatable.
- 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, unless Medically Necessary and otherwise covered under this policy.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Other limitations are shown in the "Exclusions, Expenses Not Covered and General Limitations" section.

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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:

  - **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.

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 also includes repairs to prosthetic devices.

  Coverage for prostheses/prosthetic appliances and devices and components of prosthetic devices, and repairs thereof, other than speech prostheses, is limited no more restrictively than the indications, limitations of coverage and medical necessity established under the Medicare Coverage Database. 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 artificial devices to replace, in whole or in part, a leg, an arm, or an eye. Prostheses/prosthetic appliances and devices include, but are not limited to:

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

Prostheses/prosthetic appliances and devices also include speech prostheses, such as electronic larynx devices and tracheoesophageal voice prostheses that are recommended by an otolaryngologist or speech and language pathologist following total laryngectomy.

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:

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

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

Limitations and Expenses Not Covered

For prostheses/prosthetic appliances and devices and components of prosthetic devices, other than speech prostheses, Cigna will use the limitations of coverage established under the Medicare Coverage Database.

For all other External Prosthetic Appliances and Devices, coverage for replacement of 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 of tracheoesophageal voice prostheses is limited to every three to six months or when signs of leakage or increased airflow pressure are present.

Coverage for replacement of other External Prosthetic Appliances and Devices 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 appliances and devices:

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

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Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); and the services of an embryologist.

  Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

  However, the following are specifically excluded infertility services:

  - reversal of male and female voluntary sterilization;
  - infertility services when the infertility is caused by or related to voluntary sterilization;
  - donor charges and services;
  - cryopreservation of donor sperm and eggs; and
  - any experimental, investigational or unproven infertility procedures or therapies.

HC-COV37 04-10
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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 with the exception of occupational therapy, physical therapy, and speech therapy for the treatment of children, with congenital or genetic birth defects, including autism and autism spectrum disorder:

- 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 visit.

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 limitations apply to Chiropractic Care Services:

- to be covered, all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness;
- services are not covered if they are considered custodial, training, developmental or educational in nature;
- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness;
- 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-COV710 12-17

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 all stages of reconstruction of the nondiseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and prosthetics, limited to the lowest cost alternative available that meets prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy in a manner determined in consultation with the attending Physician and the patient, are covered.

  Mastectomy means the surgical removal of all, or part, of a breast.

  Reconstructive breast surgery performed as a result of a mastectomy, means surgery to reestablish symmetry between the two breasts, including augmentation mammoplasty, reduction mammoplasty and mastopexy.

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, noncosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

HC-COV637 12-17

Transplant Services

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

  Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or 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 covered at the Out-of-Network level.

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.

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Medical Pharmaceuticals

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

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling. Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug Product first.

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

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

HC-COV602 10-16

Prescription Drug Benefits
The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a Deductible, Copayment or Coinsurance requirement for Covered Expenses for Prescription Drug Products.

As applicable, your Deductible or Coinsurance payment will be based on the Plan's Prescription Drug Charge when the Pharmacy is a Network Pharmacy, and the Usual and Customary Charge when the Pharmacy is a non-Network Pharmacy.

Coinsurance

The term Coinsurance means the percentage of charges for covered Prescription Drug Products that you or your Dependent are required to pay under this plan.

Copayments (Copay)

Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drug Products.

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% after deductible and if applicable at non-participating pharmacies, the same as the out of network medical cost share for injectable/IV chemotherapy, or at 80% after deductible, whichever is higher.

Specialty Drugs

Your cost share for a Specialty Drug will not exceed $150 per 30-day supply.

Diabetes Test Strips

Diabetes Test Strips necessary for the treatment of diabetes; or elevated blood glucose levels induced by pregnancy, are covered at 100% after deductible, if applicable.

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Calendar Year Deductible		
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
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

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Maintenance Drug Products Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Pharmacy or home delivery Pharmacy.		
Certain Preventive Care Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required.		
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy**
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $10 Copay after plan Deductible	20% after plan Deductible
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $30 Copay after plan Deductible	20% after plan Deductible
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $50 Copay after plan Deductible	20% after plan Deductible
Tier 4 Self-Administered Injectable Specialty Prescription Drug Products	No charge after $75 Copay after plan Deductible	20% after plan Deductible
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy**
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $20 Copay after plan Deductible	20% after plan Deductible
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $60 Copay after plan Deductible	20% after plan Deductible
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $100 Copay after plan Deductible	20% after plan Deductible

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Tier 4 Self-Administered Injectable Specialty Prescription Drug Products	No charge after $150 Copay after plan Deductible	20% after plan Deductible
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy**
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $20 Copay after plan Deductible	20% after plan Deductible
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $60 Copay after plan Deductible	20% after plan Deductible
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $100 Copay after plan Deductible	20% after plan Deductible
Tier 4 Self-Administered Injectable Specialty Prescription Drug Products	No charge after $150 Copay after plan Deductible	20% after plan Deductible

Prescription Drug Benefits

Covered Expenses

Your plan provides benefits for Prescription Drug Products dispensed by a Pharmacy. Details regarding your plan's Covered Expenses, Limitations and Exclusions are provided below and are shown in The Schedule**.**

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 Drug Products ordered by a Physician, Cigna will provide coverage for those expenses as shown in The Schedule. Your benefits may vary depending on which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

Coverage under your plan's Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill 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 are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered by Cigna as if filled by a Network Pharmacy. Your payment will be based on the Usual and Customary Charge submitted by the non-Network Pharmacy.

Prescription Drug List Management

The Prescription Drug List (or formulary) offered under your Employer's plan is managed by the Cigna Business Decision Team. Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. The Business Decision Team makes the final assignment of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and decides whether utilization management requirements or other coverage conditions should apply to a Prescription Drug Product by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. When considering a Prescription Drug Product for tier placement on the Prescription Drug List or other coverage conditions, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). Please access the internet through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

If you are prescribed a drug that is not on Cigna's Prescription Drug List (formulary), and in the judgment of Your prescribing Physician:

- There is no equivalent drug or device in the formulary;
- An equivalent formulary drug or device has been either ineffective in treating Your disease or condition or has been or is likely to cause an adverse reaction or other harm to You; or
- For a contraceptive prescription drug or device that is not on Cigna's Prescription Drug List, is medically necessary for You to adhere to the appropriate use of the prescription drug or device.

Call member services at the telephone number on your ID card, to get information about Cigna's procedures to cover a drug or device that is not on the Prescription Drug List.

Limitations

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the diagnosis and the Prescription Drug Product. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the Prescription Drug Product should be covered.

Prescription Drug Products prescribed for the treatment of an opioid use disorder that contains methadone, buprenorphine, or naltrexone will not be subject to any prior authorization requirements.

Cigna's formulary includes at least one Opioid Antagonist that does not require prior authorization. Opioid Antagonist means Naloxone Hydrochloride or any other similarly acting and equally safe drug approved by the FDA for the treatment of a drug overdose.

A contraceptive drug or device that is an intrauterine device, or an implantable rod, will not be subject to prior authorization requirements, if it is approved by the U.S. Food and Drug Administration, and is obtained under a prescription written by an authorized prescriber.

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Step Therapy Exception for Abuse-Deterrent Opioid Analgesic Drug Product: You will not be required to first use an Opioid Analgesic Drug Product without abuse-deterrent labeling before being providing coverage for an Abuse-Deterrent Opioid Analgesic Drug Product covered on Cigna's prescription drug list.

Step Therapy does not apply if the Prescription Drug Product is used to treat stage four advanced metastatic cancer; and use of the Prescription Drug Product is:

- consistent with the U.S. Food and Drug Administration approved indication; or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer; and
- supported by peer-reviewed medical literature.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

You may request a single dispensing of a six (6) month supply of a prescription contraceptive.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the

amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Coverage will be provided for a refill of any Prescription Drug Product prescribed for the treatment of a chronic illness, if the refill is scheduled to synchronize with your other/multiple Prescription Drug Product refills in accordance with a plan made between you, your health care practitioner and the pharmacist.

When synchronizing a refill of a Prescription Drug Product with your other Prescription Drug Products, you will pay a pro-rated copay or coinsurance for the partial supply if dispensed by an in-Network Pharmacy, and under the following conditions:

- you, and your Physician or Pharmacy believes that dispensing a partial supply of the Prescription Drug Product is in your best interest;
- it is anticipated the prescription drug will be required for more than 3 months;
- the Prescription Drug Product is not a Schedule II controlled dangerous substance; and
- the supply and dispensing of the Prescription Drug Product meet all other applicable utilization management requirements.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products. If you are beginning a therapy regimen on a Specialty Prescription Drug Product, we may limit your coverage for the initial Prescription Order or Refill to multiple, separate fills of less than the total days' supply set forth in the Schedule of Benefits. If applicable, you will pay a pro-rated Coinsurance or Copayment amount for each such supply.

Designated Pharmacies

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you may not receive coverage for the Specialty Prescription Drug Product or be subject to the non-Network Pharmacy Benefit, if any, for that Specialty Prescription Drug Product. Refer to The Schedule for further information.

New Prescription Drug Products

The Business Decision Team may or may not place a New Prescription Drug Product on a Prescription Drug List tier upon its market entry. The Business Decision Team will use reasonable efforts to make a tier placement decision for a New Prescription Drug Product within six months of its market availability. The Business Decision Team's tier placement decision shall be based on consideration of, without limitation, the P&T Committee's clinical review of the New Prescription Drug Product and economic factors. If a New Prescription Drug Product not listed on the Prescription Drug List is approved by Cigna or its Review Organization as Medically Necessary in the interim, the New Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

After satisfying the plan Deductible, if any, your responsibility for a covered Prescription Drug Product subject to a Copayment requirement will always be the lowest of:

- the Copayment for the Prescription Drug Product; or
- the Prescription Drug Charge for the Prescription Drug Product; or
- the Pharmacy's Usual and Customary (U&C) Charge for the Prescription Drug Product.

When a treatment regimen contains more than one type of Prescription Drug Products that are packaged together for you or your Dependent's convenience, any applicable Copayment or Coinsurance may apply to each Prescription Drug Product.

Any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded and Cigna or its Review Organization approves as Medically Necessary shall be covered at the applicable coverage tier as set forth in The Schedule.

The amount you or your Dependent pays for any excluded Prescription Drug Product or other product or service will not be included in calculating any applicable plan Out-of-Pocket Maximum. You are responsible for paying 100% of the cost

(the amount the Pharmacy charges you) for any excluded Prescription Drug Product or other product, and any negotiated Prescription Drug Charge will not be available to you.

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Exclusions

Coverage exclusions listed under the "Exclusions, Expenses Not Covered and General Limitations" section also apply to benefits for Prescription Drug Products. In addition, the exclusions listed below apply to benefits for Prescription Drug Products. When an exclusion or limitation applies to only certain Prescription Drug Products, you can access the internet through the website shown on your ID card or call member services at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

- coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.
- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products dispensed outside the jurisdiction of the United States, except as required for emergency or Urgent Care treatment.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government), and except for covered services that have been paid for or provided by the Department of Health and Mental Hygiene to an insured, if Cigna receives sufficient information from the department to justify reimbursement within 2 years of the service date).
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- Prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- medications used for cosmetic purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth, or medications used to control perspiration and fade cream products.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.
- Prescription Drug Products used for the treatment of male or female sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, hypoactive sexual desire disorder and decreased libido.
- any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).
- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.

- medications that are experimental investigational or unproven as described under the “General Exclusion and Limitations” section of your plan’s certificate.

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Reimbursement/Filing a Claim

Retail Pharmacy

When you or your Dependents purchase your Prescription Drug Products through a retail Network 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 purchase a Prescription Drug Product at a non-Network Pharmacy.

Home Delivery Pharmacy

To purchase Prescription Drug Products from a home delivery Network Pharmacy, see your home delivery drug introductory kit for details, or contact member services for assistance.

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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 required by state or federal law to be supplied by a public school system or school district. Behavioral care services provided by a Participating Provider will not be denied solely because it was rendered at a public school or through a school based health center.
- 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. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider, that exceed those agreed upon, if the provider has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

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

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

  In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.

The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed, and is being offered in a clinical trial approved by one of the following:

- the national institutes of health (NIH);
- an NIH cooperative group or an NIH center;
- the FDA in the form of an investigational new drug application;
- the federal department of veterans affairs; or
- an institutional review board of an institution in the state that has a multiple project assurance contract approved by the office of protection from research risks of the NIH.

- cosmetic surgery and therapies, except as specified in the "Breast Reconstruction and Breast Prostheses" section of this plan. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- the following services are excluded from coverage regardless of clinical indications: 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, 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 teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Additionally, charges made by a Physician for any of the following Surgical Procedures are covered: excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth). Charges for inpatient and outpatient services for orthodontics, oral surgery, and otologic, audiological, and speech/language treatment, involved with the management of the birth defect known as cleft lip or cleft palate, or both, are covered. Charges for diagnostic or surgical procedures involving a bone or joint of the face, neck or head if, under the accepted standards of the profession of the health care provider rendering the service, the procedure is Medically Necessary to treat a condition caused by congenital deformity, disease or Injury, are covered.
- for medical and surgical services intended for the treatment or control of obesity, except as provided for under "Covered Expenses."
- 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.
- any claim, bill or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a referral prohibited by the Maryland Health Occupations Article.
- 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), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan. However, this exclusion does not apply to charges for inpatient hospitalization services and home visits, with respect to a newborn child, as provided in the "Covered Expenses" section.
- non-medical counseling or ancillary services, including but not limited to Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and drive safety courses.
- consumable medical supplies other than ostomy supplies and urinary catheters, or as otherwise covered items. 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 beyond the rates approved by the Health Services Cost Review Commission 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, specifically: corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures

and wigs, except as may otherwise be provided for under "Covered Expenses."

- hearing aids, except as provided for under "Covered Expenses," including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- 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 non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements (except for medical foods and modified food products and amino acid-based elemental formula as provided for in the "Covered Expenses" section) and health and beauty aids.
- all nutritional supplements and formulae except for those described in the "Nutritional Products" provision of the "Covered Expenses" section.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, email, and internet consultations except as provided for under the "Telemedicine" provision in the "Covered Expenses" section.
- 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, except as specifically provided in the "Covered Expenses" section.
- 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 in the form of payment or services for medical care or treatment:

- Group and non-group insurance contracts, Health Maintenance Organization (HMO) contracts or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
- 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.

Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Primary Plan

The Plan that pays first as determined by the Order of Benefit Determination Rules below.

Secondary Plan

The Plan that pays after the Primary Plan as determined by the Order of Benefit Determination Rules below. The benefits under the Secondary Plan are reduced by the benefits under the Primary Plan.

Allowable Expense

The amount of charges considered for payment under the plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

If the benefits for a Covered Expense under your Primary Plan are reduced because you did not comply with the Primary Plan's requirements (for example, getting pre-certification of Hospital admission or a second surgical opinion), the amount of the Allowable Expense is reduced by the amount of the reduction.

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, unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice.
- 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. However, if a provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement, and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
- 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, excluding any part of a calendar year during which you are not covered under this Plan or any date before this section or any similar provision takes effect.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

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 that applies:

- The Plan that covers the person other than as a Dependent, for example as an employee, enrollee, policyholder, subscriber, member or retiree is the Primary plan and the Plan that covers the person as a Dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, enrollee, policyholder, subscriber, member, or retiree is the Secondary plan and the other Plan is the Primary plan.
- Unless there is a court decree stating otherwise, if you are a Dependent child covered by more than one Plan the order of benefits is determined as follows:
  a) If you are a Dependent child whose parents are married, or living together, whether or not they have ever been married, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year. If both parent have the same birthday, the plan that has covered the parent the longest is the Primary Plan;
  b) If you are the Dependent of parents who are divorced or separated, or not living together, whether or not they have ever been married, benefits shall be determined in the following order:
    - If a court decree states that one parent is responsible for the Dependent child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, that Plan is Primary. The following rules apply from the time the Plan receives notice of a court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
    - If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      - then, the Plan of the Custodial parent;
      - then, the Plan of the spouse of the Custodial parent;
      - then, the Plan of the non-Custodial parent; and
      - finally, the Plan of the spouse of the non-Custodial parent.
    - If you are a Dependent child covered under more than one Plan of individuals who are not your parents, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were your parents.
    - If you are a Dependent child who has coverage under either or both parents' plans and you also have coverage as a Dependent under your spouse's plan, the Plan that has covered you the longest is the Primary Plan. In the event your coverage under your spouse's plan began on the same date as your coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule to your parents and spouse.
- 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 COBRA, or 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.
- The Plan that covers you as an Employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covers you the shorter period of time is the Secondary Plan.
- If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary Plan.

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

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If while covered under this Plan, you are also covered by another Cigna individual or group Plan, you will be entitled to the benefits of only one Plan. You may choose this Plan or the Plan under which you will be covered. Cigna will then refund any premium received under the other Plan covering the time period both policies were in effect. However, any claim payments made by Cigna under the Plan you elected to cancel will be deducted from any such refund of premium.

Recovery of Excess Benefits

If this Plan is the Secondary Plan and Cigna pays for Covered Expenses that should have been paid by the Primary Plan, or if Cigna pays any amount in excess of what it is obligated to pay, Cigna will have the right to recover the actual overpayment made.

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

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under 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.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, Cigna may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Cigna will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

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.

HC-COB190 12-17

Expenses For Which A Third Party May Be Responsible

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. Any amount refunded to the insurance company will be reduced by a pro rata share of the court costs and legal fees incurred by the insured which are applicable to the portion of the settlement returned to the insurance company.

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. The amount of the lien will be reduced by a pro rata share of any court costs and attorney's fees incurred by the insured which are applicable to the portion of the settlement returned to the insurance company;
- 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.
- The plan shall 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.
- 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.
- Participants must assist the plan in pursuing any recovery rights by providing requested information.

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Payment of Benefits

Time of Payment of Claims

Benefits payable under the policy will be paid not more than 30 days after receipt of written proof of loss.

Provider Compensation: Assignment of Benefits

Assignment and Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make

a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances. You may, however, authorize Cigna to pay any healthcare benefits under this policy to a Participating or non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Services directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you, refuse to directly reimburse a non-Participating Provider if:

- Cigna receives notice of the assignment of benefits after Cigna has paid the benefits to you;
- Cigna, due to an inadvertent administrative error, has previously paid you;
- You withdraw the assignment of benefits before Cigna has paid the benefits to the non-Participating Provider; or
- You paid the non-Participating Provider the full amount due at the time of service.

When benefits are paid to you or your Dependents are responsible for reimbursing the non-Participating Provider.

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

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, pay the benefit, up to an amount not exceeding $5,000, to any relative by blood or connection in marriage of the individual who is considered by Cigna to be equitably entitled to the benefit.

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 to: recover that overpayment from the provider or entity to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment within 18 months of the date the claim was paid if the benefits were subject to coordination of benefits; or within 6 months of the date the claim was paid for all other claims. Your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

When Cigna retroactively denies reimbursement, it will provide a written statement specifying the basis for the retroactive denial. If the retroactive denial results from COB, the written statement will provide the name and address of the carrier acknowledging responsibility for payment of the denied claims, unless retroactive denial results because: a) the information submitted to the carrier was fraudulent; b) the information submitted was improperly coded and Cigna provided sufficient information regarding the coding guidelines used to the provider at least 30 days prior to the date the services subject to retroactive denial were rendered; or c) the claim submitted was a duplicate claim.

If Cigna retroactively denies as a result of COB, the provider has 6 months from the date of the denial, unless Cigna permits a longer time period, to submit a claim for reimbursement to the carrier, the MD Medical Assistance Program or Medicare Program responsible for payment.

A claim may be considered improperly coded if the claim uses codes that do not conform with Cigna's coding guidelines as of the date the service or services were rendered or the claim does not otherwise conform with the contractual obligations of the provider that are applicable as of the date service or services were rendered.

Calculation of Covered Expenses

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

- the methodologies in the most recent edition of the Current Procedural terminology.

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

HC-POB100 10-16

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: stops paying premium for you; or otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. Coverage will be continued until the earlier of: the date you cease to be totally disabled; or 12 months after the date coverage terminates.

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.

Notice of Termination of Eligibility

The Employer must provide Cigna with written notice of the termination of eligibility for any Employee or Dependent. If Cigna receives Notice of Termination within 60 days of the date of the loss of eligibility, coverage for the individual will cease at midnight on the day loss of eligibility occurs. If Notice of Termination is not received within 60 days of the date of loss of eligibility, then coverage for the individual will cease at midnight on the date which is 60 days prior to the date Cigna receives Notice of Termination.

HC-TRM130 12-17

Continuation

Special Continuation of Medical Insurance

For Employees

If your Insurance ceases because:

- you are involuntarily terminated from employment other than for cause; or
- you voluntarily terminated your employment;

and if you have been insured for at least 3 consecutive months, you may continue the insurance by paying the required premium to your Employer. In no event will your insurance be continued beyond the earliest of:

- 18 months from the date your employment ends;
- the last day for which you have paid the required contribution;
- the date you become eligible for similar group coverage or entitled to benefits under Medicare; or
- the date the Group Policy cancels.

If your insurance ceases because you are terminated from employment for cause, you may continue the insurance by paying the required premium to your Employer. In no event will your insurance be continued beyond the earliest of:

- 6 months from the date your employment ends;
- the last day for which you have paid the required premium; or
- the date you become eligible for similar group coverage or entitled to benefits under Medicare.

Provisions Regarding Notification of Special Continuation

Your Employer will provide you with an election notification form no later than 14 days after the receipt of your request for continuance. You may elect the continuance by signing the election notification form and submitting it to your Employer no later than 45 days after your employment ends.

For Dependents

If your insurance is being continued as described above, Medical Insurance may be continued for those Dependents insured on the date your employment ends, subject to the provisions set forth above. The Insurance will continue until the earlier of:

- the date your insurance ceases, except in the case of your death; or
- for any one Dependent, the earlier of: the date that Dependent becomes eligible for similar group coverage or entitled to benefits under Medicare, or the date that Dependent no longer qualifies as a Dependent for any reason other than your death.

For Dependents of Deceased Employees

If you die while insured for Medical Insurance and if you have been insured at least 3 consecutive months, your Eligible Dependents may continue their insurance by paying the required premium to your Employer. Eligible Dependents are: your Dependent children who are insured at the time of your death or are born to your Eligible Dependent spouse after your death; and your Dependent spouse, providing that person was insured as your Dependent spouse for a 30-day period immediately preceding your death. The Insurance may not be continued beyond the earliest of:

- 18 months from the date of your death;
- the last day for which the required contribution has been paid;
- for any one Dependent, the earlier of: the date that Dependent becomes eligible for similar group coverage or entitled to benefits under Medicare; or for a Dependent child, the date that Dependent no longer qualifies as a Dependent for any reason other than your death; or
- the date the Group Policy cancels.

Provisions Regarding Notification of Special Continuation

Your Employer will provide any Eligible Dependent with an election notification form no later than 14 days after receipt of that Dependent's request for continuance. The Eligible Dependent may elect the continuance by signing the election notification form and submitting it to your Employer no later than 45 days after your death.

Conversion Available Following Continuation

The provisions of the "Medical Conversion Privilege" section will apply following the termination of insurance.

The terms of this section will not reduce any continuation of insurance otherwise provided.

For Spouse and Children Upon Divorce From Employee

If your spouse's and any children's Medical Insurance would otherwise cease because of divorce, the insurance may be continued under the policy for your Eligible Dependents, provided you or your spouse pay or share the cost of the required contribution to your Employer. Eligible Dependents are: your former spouse, provided that person was insured as your Dependent spouse for a 30-day period immediately preceding the divorce; your children, provided they were insured as your Dependent children immediately prior to the divorce; and any child or children born to your former spouse after the divorce. In no event will the insurance continue beyond the earliest of:

- the last day for which you have paid the required contribution;
- the date your former spouse remarries, with respect to the former spouse’s continued insurance;
- for any one Dependent: for a Dependent child, the date that Dependent ceases to qualify as a Dependent for any reason other than divorce; the date that Dependent becomes eligible for similar group coverage, entitled to benefits under Medicare or accepts non-group coverage; or the date that Dependent no longer elects to be insured under the policy;
- the date you are no longer insured under the policy;
- the date the Group Policy cancels;
- the date you cease to be in a Class of Employees eligible for Dependent Insurance; or
- the date Dependent Insurance is canceled.

A written notice of the termination of coverage for your spouse or Dependent child must be given to your Employer when: that Dependent ceases to qualify as a Dependent for any reason other than divorce; that Dependent becomes eligible for similar group coverage or entitled to benefits under Medicare; that Dependent no longer elects to be insured under the policy; or your former spouse remarries. The termination statement form is available from your Employer.

Effect of Remarriage of Employee

If you remarry: an additional contribution will be required for your former spouse; and any provision for continuation of insurance after your death, other than as provided in this "Special Continuation of Medical Insurance" section, will not apply.

Conversion Available Following Continuation

The provisions of the "Medical Conversion Privilege" section will apply following the termination of insurance.

The terms of this section will not operate to reduce any continuation of insurance otherwise provided, except as shown above in the paragraph entitled "Effect of Remarriage of Employee."

HC-TRM8 04-10
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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. You will be provided at least 30 days advance written notice of any rescission.

HC-TRM80 01-11
V3

Medical Benefits Extension Upon Coverage Termination

If the Medical Benefits under this plan cease for you or your Dependent due to the termination of your or your Dependent's coverage, and you or your Dependent is Totally Disabled on that date due to Injury or Sickness, or you or your Dependent is Confined in a Hospital, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury or Sickness until the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in The Schedule;
- the date you are neither Totally Disabled nor Confined in a Hospital; or
- 12 months after the date coverage ends.

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.

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.

Cigna may, at any time, require you or your Dependent to provide proof of Total Disability.

This section will not apply, however, if: coverage is terminated because an individual fails to pay a required premium; coverage is terminated for fraud or material misrepresentation by the individual; or any coverage provided by a succeeding health benefit plan is provided at a cost to the individual that is less than or equal to the cost of the extended benefit required under this mandate, and does not result in an interruption of benefits.

Benefits Extension in Connection with Dental Care Services

Benefits for Covered Expenses incurred in connection with dental care services will be extended for 90 days after the date a person's coverage terminates. Covered Expenses will be deemed to be incurred while he or she is insured if the treatment:

- begins before the date coverage terminates; and
- requires two or more visits on separate days to a dentist’s office.

HC-BEX4 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 Directories and Provider Networks

A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice,

affiliated or contracted with Cigna or an organization contracting on its behalf.

Notice Regarding Pharmacy Directories and Pharmacy Networks

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

HC-FED78 10-10

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 no later than the first day of the first calendar month following receipt of the request for special enrollment.

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

HC-FED96 04-17

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 you meet Special Enrollment criteria and enroll as described in the Special Enrollment section; or
- if your Employer agrees, and you meet the criteria shown in the following Sections B through H and enroll for or change coverage within the time period established by your Employer.

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 a 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-FED95 04-17

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

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

HC-FED93 10-17

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you

and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

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

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA 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

Claim Determination Procedures

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

Procedures Regarding Medical Necessity Determinations

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

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

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

Preservice Determinations

When you or your representative requests a required prior authorization, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna will defer to the determination of the treating health care professional regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited

determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow Cigna's procedures for requesting a required preservice determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Determinations

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

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; 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, (if applicable); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; a description of any available internal appeal and/or external review process(es); information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

HC-FED79 03-13

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-SPP4V2
04-10

Appointment of Authorized Representative

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

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

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

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

HC-AAR1 01-17

When You Have A Complaint, An Appeal Or A Grievance

Definitions

Adverse Decision

An Adverse Decision is a utilization review determination by Cigna that: a proposed or delivered Health Care Service covered under the insured's contract is or was not Medically Necessary, appropriate, or efficient; and may result in noncoverage of the Health Care Service.

Appeal

An Appeal is a protest filed by an Insured, his or her representative or a health care provider with Cigna under its internal Appeal process regarding a Coverage Decision concerning an insured.

Appeal Decision

An Appeal Decision is a final determination by Cigna that arises from an Appeal filed with Cigna under its Appeal process regarding a Coverage Decision concerning an insured.

Compelling Reason

A Compelling Reason includes showing that the potential delay in receipt of a health care service until after the insured or health care provider exhausts the internal Grievance process and obtains a final decision under the Grievance process could result in:

- Loss of life;
- Serious impairment to a bodily function;
- Serious dysfunction of a bodily organ;
- The insured remaining seriously mentally ill or using intoxicating substances, with symptoms that cause the insured to be in danger to self or others; or
- The member continuing to experience severe withdrawal symptoms.

A member is considered to be in danger to self or others if the member is unable to function in activities of daily living or care for self without imminent dangerous consequences.

Complaint

A Complaint is a protest filed with the Maryland Insurance Commissioner involving an Adverse Decision or Grievance Decision concerning the insured; or a protest filed with the Commissioner involving a Coverage Decision.

Emergency Case

Emergency Case means a case involving an adverse decision for which an expedited review is required by law.

Grievance

A Grievance is a protest by an insured, his or her representative or a health care provider on behalf of the insured filed with Cigna through its internal Grievance process regarding an Adverse Decision concerning the insured.

Grievance Decision

A Grievance Decision by Cigna is a final determination that arises from a Grievance regarding an Adverse Decision concerning the insured, which was filed with Cigna under its internal Grievance process.

Health Care Provider

A Health Care Provider means: an individual who is licensed under the Maryland Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession, and is a treating provider of the insured; or a Hospital, as defined by Maryland law.

Health Care Service

A Health Care Service is a health or medical care procedure or service rendered by a health care provider that: provides testing, diagnosis, or treatment of a human disease or dysfunction; or dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

Medically Necessary/Medical Necessity

Medically Necessary/Medical Necessity refer to health care services and supplies which are determined by Cigna to be: medically required to meet the basic health needs of the insured; consistent with the diagnosis of the condition; consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; required for purposes other than the comfort and convenience of the patient or his Physician; and of demonstrated medical value.

Member's Representative

Member's Representative means an individual who has been authorized by the member to file a grievance or a complaint on the member's behalf.

Private Review Agent:

"Private review agent" means:

- a nonhospital-affiliated person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of:
  - a Maryland business entity; or
  - a third party that pays for, provides, or administers health care services to citizens of this State; or
- any person or entity including a Hospital-affiliated person performing utilization review for the purpose of making claims or payment decisions for health care services on behalf of the employer's or labor union's health insurance plan under an employee assistance program for employees other than the employees employed by:
  - the Hospital; or
  - a business wholly owned by the Hospital.

Any services precertified by the Review Organization will be deemed Medically Necessary.

When You Have a Complaint, an Appeal or a Grievance

For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or your treating provider designated by you to act on your behalf; and "Physician reviewers" are licensed Physicians depending on the care, treatment or service under review.

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 Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Services toll-free number that appears on your benefit identification card, explanation of benefits or claim form.

Quality of Care Issues

Quality of Care Issues include the following: malpractice allegation; negative patient outcomes related to poor care; failure to follow up on diagnostic procedures; failure to provide treatment for presenting complaints consistent with standard of care; failure to appropriately document medical records; confidentiality and privacy issues related to medical records or care; dissatisfaction of providers; qualifications of providers; misdiagnosis; inappropriate referrals; environmental issues related to infection control and hazardous medical waste; failure of a provider to perform adequate medical screening, assessments, or emergency care; failure to provide an adequate internal insured complaint process concerning quality of care issues; failure to comply with policies and procedures concerning delivery of care; inadequate credentialing and performance appraisal for Physician; and denial of Health Care Service benefits by Cigna.

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, such as a claim denial or other adverse determination, or a rescission of coverage, you can start the Administrative Appeals Procedure or Medical Necessity Grievance Procedure.

Internal Appeals and Grievance Procedure

Cigna has a one-step Appeals and Grievance Procedure for Coverage Decisions and decisions involving Medical Necessity. To initiate an Administrative Appeal or Medical Necessity Grievance, you must submit a written request for an Appeal or Grievance within 365 days of receipt of a denial notice, to the following address:

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

For decisions involving Medical Necessity, a denial notice is the same as an Adverse Decision. Notice of an Adverse Decision must be sent by us within five working days after the decision is made. You should state the reason why you feel your Appeal or Grievance should be approved and include any information supporting your Appeal or Grievance. If you are unable or choose not to write, you may ask to register your Appeal or Grievance by calling the toll-free number on your benefit identification card, explanation of benefits or claim form. If we determine that we do not have sufficient information to complete our review, you will be notified within five working days after the Filing Date of your Grievance and will be assisted by us, without further delay, in gathering the necessary information.

Filing Date means the earlier of: five days after the date of mailing or the date of receipt.

Medical Necessity Grievance Procedure

Your request to reconsider an Adverse Decision will be reviewed and the decision made by someone not involved in the initial decision. Grievances involving Medical Necessity will be considered by a Physician reviewer who is board certified or eligible in the same specialty as the treatment under review. The Medical Director who has responsibility for oversight of Grievance decisions is:

Zehra Jung, MD, MHA, CPE
Medical Director
Cigna Healthcare
701Corporate Center Dr.
Raleigh, NC 27607
Telephone Number: 800-558-7390, OPT3

We will make a decision and will notify you in writing of our decision, both within 30 calendar days of the Filing Date of your Grievance request, unless you agree in writing to an extension for a period of no longer than 15 calendar days. 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.

In no case will written notice of the Grievance decision be sent later than five working days after the Grievance decision has been made.

Decisions involving a Grievance request in connection with a retrospective denial will be made within 45 working days after the date on which the Grievance is filed. The decision will be communicated to you in writing.

Expedited Medical Necessity Grievance Procedure

An expedited Grievance is available for services that are proposed, but which have not yet been rendered. When requested and when the time frames under this process would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or would cause you to be a danger to self or others, or would cause you to continue using intoxicating substances in an imminently dangerous manner, we will respond verbally with a decision within 24 hours of the date a Grievance is filed, followed up in writing within one calendar day of the verbal response.

If you request that your Appeal be expedited because the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited Grievance would be detrimental to your medical condition.

Administrative Appeal Procedure

Your request to reconsider a Coverage Decision will be reviewed and the decision made by someone not involved in the initial decision. We will make a final Appeal Decision and will notify you in writing of our decision, both within 30 calendar days of your request. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. 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.

Expedited Administrative Appeal Procedure

You may also request that the Appeal process be expedited if the time frames under this process would result in: serious jeopardy to your life or health; your inability to regain maximum function; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; your remaining seriously mentally ill with symptoms that cause you to be a danger to self or others; the opinion of a health care provider with knowledge of your medical condition, severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage Decision; or if your Appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your Appeal be expedited because the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited Grievance would be detrimental to your medical condition.

The Physician reviewer, in consultation with the treating Physician, will decide if an expedited Appeal is necessary. When an Appeal is expedited, we will respond verbally with a decision within 72 hours, followed up in writing.

Appeals to the State of Maryland

Medical Necessity Grievance

If you are not fully satisfied with the final decision of Cigna's Grievance review regarding your Medical Necessity issue, you have the right within four months to file a Complaint with the Maryland Insurance Commissioner. The Complaint may be filed without first filing a Grievance if:

- we have waived the requirements for you to participate in our internal Grievance process;
- we have failed to follow any of the requirements of our internal Grievance process; or
- you can demonstrate to the Commissioner a Compelling Reason to do so.

You may also file a Complaint with the Commissioner if we fail to make a decision on a Medical Necessity Grievance within the required time frames, including if a Grievance decision is not received within 24 hours for an Expedited Medical Necessity Grievance. The Commissioner may be contacted at the following address, telephone number, and fax number:

Maryland Insurance Administration
Appeals and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Telephone Number:
410-468-2000 or 1-800-492-6116
Fax Number: 410-468-2270
TTY 1-800-735-2258

The Health Advocacy Unit is available to assist you in both mediating and filing a Grievance under our internal Grievance process. You may contact the Health Advocacy Unit of Maryland's Consumer Protection at:

Office of the Attorney General
Consumer Protection Division
200 St. Paul Place, 16th Floor
Baltimore, MD 21202

The Unit can also be reached by calling 410-528-1840 or 1-877-261-8807 (phone), TTY 1-800-735-2258 or 410-576-6571 (fax) or by e-mail heau@oag.state.md.us.

When you file a Complaint with the Commissioner, you will be required to authorize the release of any of your medical records that may be required to be reviewed in order to reach a decision on your Complaint.

Administrative or Other Appeals

If you are not satisfied with the final Appeal Decision, you have the right within four months to file a Complaint with the Maryland Insurance Commissioner. The Administration may be contacted at the following address and telephone number:

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Telephone Number: 410-468-2000
TTY 1-800-735-2258

When filing a Complaint with the Commissioner, the member or the member's representative will be required to authorize the release of any medical records of the member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

The Complaint may be filed with the Commissioner without first filing an Appeal, and receiving a final decision if: the Complaint is the subject of an initial Coverage Decision that involves care which has not yet been rendered, and you give sufficient information and supporting documentation in the Complaint that demonstrates an Urgent Medical Condition exists.

If a case involves a retrospective denial, an Urgent Medical Condition that would allow you to file a Complaint is not deemed to exist unless you have first exhausted Cigna's internal Appeal process.

Coverage Decision means: an initial determination by us that results in noncoverage of a Health Care Service; a determination by us that an individual is not eligible for coverage under a health benefit plan; or any determination by us that results in the rescission of an individual's coverage under a health benefit. This includes nonpayment of all or any part of a claim. Coverage Decision does not include decisions based on Medical Necessity.

Urgent Medical Condition means a condition that satisfies either of the following:

- medical condition, including a physical condition, mental condition, or a dental condition where the absence of medical attention within 72 hours could reasonably be expected, by a prudent layperson who possesses an average knowledge of health and medicine, to result in:
  - serious jeopardy to your life or health;
  - your inability to regain maximum function;
  - serious impairment to bodily functions;
  - serious dysfunction of any bodily organ or part; or
  - you remaining seriously mentally ill with symptoms that cause you to be a danger to self or others; or
- medical condition, including a physical condition, mental condition, or a dental condition where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without care or treatment that is the subject of the Coverage Decision.

The Health Advocacy Unit is available to assist you in both mediating and filing an Appeal under our internal Appeal process. You may contact the Health Advocacy Unit of Maryland's Consumer Protection at:

Office of the Attorney General
Consumer Protection Division
200 St. Paul Place, 16th Floor
Baltimore, MD 21202

The Unit can also be reached by calling 410-528-1840 or 1-877-261-8807 (phone), TTY 1-800-576-6372 or 410-576-6571 (fax) or by e-mail at heau@oag.state.md.us.

Legal Action

Legal Action may not be brought against Cigna before the expiration of 60 days after written proof of loss has been furnished in accordance with the terms of this Certificate, or after the expiration of 3 years after the written proof of loss is required to be furnished. However, no action will be brought at all unless brought within 3 years after proof of loss is submitted for In-Network Services or for Out-of-Network services.

Notice of Benefit Determination on Appeal

Every notice of a determination on Appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary Appeal procedures offered by the plan 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.

In addition, notice of determination on an Appeal or Grievance will also include the following:

- for Administrative Appeals:
  - notice of the member's right to submit a Complaint to the Commissioner within four months of receipt of a decision;
  - the Commissioner's address, telephone number and fax number; and
  - a statement that the Health Advocacy Unit is available to assist you in filing a Complaint with the Commissioner, along with the address, telephone number, facsimile number and e-mail address of the Health Advocacy Unit.
- for Medical Necessity Grievances:
  - in clear and understandable language, the detailed, specific, factual bases for Cigna's decision;
  - the specific criteria and standards, including interpretive guidelines used; without solely using generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not Medically Necessary";
  - written details of the carrier's internal grievance process and procedures;
  - the name, business address, and telephone number of the designated representative who has responsibility for the internal Grievance process;
  - notice of member's right to file a Complaint with the Commissioner within four months of receipt of a Grievance Decision;
  - the Commissioner's address; telephone number and fax number;
  - a statement that the Health Advocacy Unit is available to assist you in filing a Complaint with the Commissioner, along with the address, telephone number, facsimile number and e-mail address of the Health Advocacy Unit; and
  - a statement that a complaint may be filed without first filing a grievance if the member, the member's representative, or a health care provider filing a grievance on behalf of the member can demonstrate a Compelling Reason to do so as determined by the Commissioner.

HC-APL288 12-17

Definitions

Abuse-Deterrent Opioid Analgesic Drug Product

Abuse-Deterrent Opioid Analgesic Drug Product means a brand name or generic Opioid Analgesic Drug Product approved by the U.S. Food and Drug Administration with abuse-deterrent labeling that indicates the drug product is expected to result in a meaningful reduction in abuse.

HC-DFS942 10-16

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-DFS1095 12-17

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

Biologic

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS840 10-16

Biosimilar

A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS841 10-16

Brand Drug

A Prescription Drug Product that Cigna identifies as a Brand Drug product across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the plan.

HC-DFS842 10-16

Business Decision Team

A committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to make decisions regarding coverage treatment of Prescription Drug Products or Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to Prescription Drug Products or Medical Pharmaceuticals.

HC-DFS843 10-16

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

Cigna Home Delivery Pharmacy

A home delivery Network Pharmacy owned and operated by licensed Pharmacy affiliates of Cigna Health and Life Insurance Company.

HC-DFS844 10-16

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; 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.

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

The term child means: a child born to you, a stepchild, an adopted child or grandchild; a child placed with you for legal adoption; or a child who is entitled to dependent coverage under testamentary or court-ordered guardianship (other than temporary guardianship of less than 12 months duration). Coverage is provided for the Injury or Sickness of a newly born or newly adopted dependent child or grandchild (as defined) from the moment of birth or Date of Adoption of the child or grandchild. Coverage for a minor for whom guardianship is granted by court or testamentary appointment is payable from the date of appointment. Coverage includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Date of Adoption means the earlier of:

- a judicial decree of adoption; or
- the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.

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 spouse. A child under age 26 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee.

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

HC-DFS934 10-16

Designated Pharmacy

A Network Pharmacy that has entered into an agreement with Cigna, or with an entity contracting on Cigna's behalf, to provide Prescription Drug Products or services, including, without limitation, specific Prescription Drug Products, to plan enrollees on a preferred or exclusive basis. For example, a Designated Pharmacy may provide enrollees certain Specialty Prescription Drug Products that have limited distribution availability, provide enrollees with an extended days' supply of Prescription Drug Products or provide enrollees with Prescription Drug Products on a preferred cost share basis. The fact that a Pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

HC-DFS845 10-16

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; or a health care item or service furnished or required to evaluate and treat 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.

In an emergency situation, you should call 911 for Maryland or other state, county, or local emergency medical services.

Pre-authorization for this service is not required.

HC-DFS432 04-10
V1

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 40 hours a week for the Employer.

HC-DFS1094 12-17

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

Essential Health Benefits

Essential health benefits has the meaning found in section 1302(b) of PPACA and as further defined by the Secretary of the U.S. Health and Human Services Department, and includes, 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-DFS491 04-10
V1

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.

The term Free-Standing Surgical Facility also includes a Birthing Center.

HC-DFS97 04-10
V1

Generic Drug

A Prescription Drug Product that Cigna identifies as a Generic Drug product at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics (including Biosimilars) as either brand or generic based on a number of factors. Not all products identified as a “generic” by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the plan. A Biosimilar may be classified as a Generic Drug for the purposes of benefits under the plan even if it is identified as a “brand name” drug by the manufacturer, Pharmacy or your Physician.

HC-DFS846 10-16

Habilitative Services

Habilitative Services are services and devices, including occupational therapy, physical therapy, and speech therapy, that helps a child keep, learn, or improve skills and functioning for daily living. Habilitative Services also includes criteria for behavioral health treatment, psychological care, and therapeutic care.

Behavioral health treatment means professional counseling and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

Psychological care means direct or consultative services provided by a Psychologist licensed in the state in which the services are provided or by a social worker licensed in the state in which the services are provided. Psychological care includes psychotherapy.

Therapeutic care means services provided by a speech-language pathologist, occupational therapist, or physical therapist licensed in the state in which the services are provided.

Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

HC-DFS1048 08-17

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 immediate families or family caregivers of those persons.

HC-DFS98 04-10
V1

Hospice Care Services

The term Hospice Care Services means a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement to: individuals who have no reasonable prospect of cure as estimated by a Physician; and the immediate families or family caregivers of those individuals.

HC-DFS99 04-10
V1

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients; and
- fulfills any licensing requirements of the state or locality in which it operates.

HC-DFS100 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 Use Disorder or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

HC-DFS817 11-15
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 Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

HC-DFS807 12-15
V1

Immediate Family

The term Immediate Family means the spouse, parents, siblings, grandparents and children of the terminally ill insured.

HC-DFS101 04-10
V1

Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

Maintenance Drug Product

A Prescription Drug Product that is prescribed for use over a period of time of 6 months or more for the treatment of chronic conditions such as asthma, hypertension, diabetes and heart disease. For the purposes of benefits, the list of your plan's Maintenance Drug Products does not include compounded medications or Prescription Drug Products, such as certain narcotics that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or Refill under applicable federal or state law. You may determine whether a drug is a Maintenance Medication by calling member services at the telephone number on your ID card.

HC-DFS938 10-16

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 percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database, then data in the database for similar services may be used.

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

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

General Reimbursement Information

In no event will Cigna's allowed amount paid to a non-Participating Provider (Out-of-Network Provider) for a covered health care service be less than the allowed amount paid to a similarly licensed provider who is a Participating Provider, for the same service in the same geographical region.

The following applies to on-call Physicians and Hospital-based Physicians who are licensed in Maryland:

With respect to on-call Physicians and Hospital-based Physicians who:

- are non-Participating Providers or Out-of-Network Providers; and
- obtain an assignment of benefits from the insured person; and
- notify Cigna, in the manner specified by the Commissioner of Insurance, that the on-call Physician or Hospital-based Physician has obtained and accepted the assignment of benefits from the insured person.

Cigna agrees as follows:

- Cigna will pay the on-call Physician or Hospital-based Physician, within 30 days after receipt of the claim; and
- On-call and Hospital-based Physicians who are licensed in Maryland may not attempt to collect from the insured person any amount in excess of the allowable amount; and
- The allowable amount used to determine the plan's benefit payment for a claim submitted by an on-call Physician, for a covered service rendered to an insured in a Hospital, no less than the greater of:
  - 140% of the average rate Cigna paid for the 12-month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service, to similarly licensed providers under written contract with Cigna; or
  - the average rate Cigna paid for the 12-month period that ended on January 1, 2010, in the same geographic area, as

defined by the Centers for Medicare and Medicaid Services, for the same covered service to a similarly licensed provider not under written contract with Cigna, inflated by the change in the Medicare Economic Index from 2010 to the current year.

- The allowable amount used to determine the plan's benefit payment for a claim submitted by a Hospital-based Physician, for a covered service rendered to an insured, no less than the greater of:
  - 140% of the average rate Cigna paid for the 12-month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service, to similarly licensed providers who are Hospital-based Physicians under written contract with Cigna; or
  - the final allowed amount of Cigna for the same covered service for the 12-month period that ended on January 1, 2010, inflated by the change in the Medicare Economic Index to the current year, to the Hospital-based Physician billing under the same federal tax identification number the Hospital-based Physician used in calendar year 2009.

HC-DFS1097 12-17

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

Medical Pharmaceutical

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

HC-DFS848 10-16

Medically Necessary/Medical Necessity

Healthcare services, supplies, and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:

- 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;
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

Preventive care services described in this certificate are considered to be Medically Necessary.

HC-DFS935 11-1

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 or dental fees.

HC-DFS103 04-10
V1

Network Pharmacy

A retail or home delivery Pharmacy that has:

- entered into an agreement with Cigna or an entity contracting on Cigna's behalf to provide Prescription Drug Products to plan enrollees.
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- been designated as a Network Pharmacy for the purposes of coverage under your Employer's plan.

HC-DFS849 10-16

New Prescription Drug Product

A Prescription Drug Product, or new use or dosage form of a previously FDA-approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or newly-approved use or dosage form becomes available on the market following approval by the U.S. Food and Drug Administration (FDA) and ending on the date Cigna's Business Decision Team makes a Prescription Drug List coverage status decision.

HC-DFS850 10-16

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." The term Nurse also includes a nurse practitioner, nurse anesthetist and nurse midwife.

HC-DFS104 04-10
V1

Opioid Analgesic Drug Product

Opioid Analgesic Drug Product means a drug product that contains an opioid agonist and is indicated by the U.S. Food and Drug Administration for the treatment of pain, regardless of whether the drug product is: in immediate release or extended release form; or contains other drug substances.

HC-DFS941 10-16

Other Health Care Facility

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.

HC-DFS492 04-10
V1

Other Health Professional

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 Graduate Nurses and Licensed Practical Nurses.

The term Other Health Professional does not include 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-DFS493 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

A duly licensed Pharmacy that dispenses Prescription Drug Products in a retail setting or via home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drug Products through mail order.

HC-DFS851 10-16

Pharmacy & Therapeutics (P&T) Committee

A committee comprised of both voting and non-voting Cigna-employed clinicians, Medical Directors and Pharmacy Directors and non-employees such as Participating Providers that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals or Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

HC-DFS852 10-16

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 Charge

The amount Cigna charges to the Plan, including the applicable dispensing fee and any applicable sales tax and prior to application of any Deductible, Copayment or Coinsurance amounts, for a Prescription Drug Product dispensed at a Network Pharmacy. Cigna may pay a Network Pharmacy a different amount for a Prescription Drug Product than the Plan pays to Cigna. You are not entitled to the difference between the rate Cigna charges to the Plan and the rate Cigna pays to the Pharmacy for a Prescription Drug Product. For the purposes of Prescription Drug benefit payments, the "Plan" is the entity or business unit responsible for funding benefits in accordance with the terms and conditions outlined in this booklet/certificate.

HC-DFS1098 12-17

Prescription Drug List

A list that categorizes drugs, Biologics (including Biosimilars) or other products covered under the plan's Prescription Drug Benefits that have been approved by the U.S. Food and Drug Administration (FDA) into coverage tiers. This list is developed by Cigna's Business Decision Team based on clinical factors communicated by the P&T Committee, and adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.

HC-DFS854 10-16

Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the plan, this definition also includes:

- The following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (but excluding insulin pumps), needles

including pen needles, syringes, test strips, lancets, urine glucose and ketone strips;

- Needles and syringes for self-administered medications or Biologics covered under the plan's Prescription Drug benefit; and
- Inhaler assistance devices and accessories, peak flow meters.

This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

HC-DFS855 10-16

Prescription Order or Refill

The lawful directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

HC-DFS856 10-16

Preventive Care Medications

The Prescription Drug Products or other medications (including over-the-counter medications) designated as payable by the plan at 100% of the cost (without application of any Deductible, Copayment or Coinsurance) as required by applicable law under any of the following:

- 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.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

A written prescription is required to process a claim for a Preventive Care Medication. You may determine whether a drug is a Preventive Care Medication through the internet website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-DFS857 10-16

Primary Care Physician

The term Primary Care Physician means a Physician: who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and who has been selected by you, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

Primary Care Physician also includes obstetricians and gynecologists. However, if an obstetrician or gynecologist chooses not to be a Primary Care Physician, you or your Dependent are entitled to receive routine gynecological care from an In-Network obstetrician/gynecologist without visiting a Primary Care Physician first, if:

- the care is Medically Necessary, including care that is routine;
- after each visit for gynecological care, the obstetrician/gynecologist communicates with your or your Dependent's Primary Care Physician about any diagnosis or treatment rendered; and
- the obstetrician/gynecologist confers with the Primary Care Physician before performing any diagnostic procedure that is not routine gynecological care rendered during an annual visit.

HC-DFS438 04-10
V1

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

Respite Care

The term Respite Care means temporary care provided to the terminally ill insured to relieve the family caregiver from the daily care of the insured.

HC-DFS106 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 use disorder professionals, and other trained staff members who perform utilization review services.

HC-DFS808 12-15

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Sickness also means cleft lip and cleft palate including inpatient and outpatient expenses arising from orthodontics, oral surgery, otologic, audiological and speech/language treatment in connection with that condition. Any dental exclusions will not apply to cleft lip and cleft palate. Further, 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-DFS107 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, or pediatrics.

HC-DFS439 04-10
V1

Specialty Prescription Drug Product

A Prescription Drug Product or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Prescription Drug Product or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug Product or Medical Pharmaceutical has a high acquisition cost; and, whether the Prescription Drug Product or Medical Pharmaceutical is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug Product or Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, or by tier assignment or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

A Specialty Prescription Drug Product includes Specialty Drugs meeting the following:

- is prescribed for an individual with a complex or chronic medical condition or a rare medical condition;
- costs six hundred dollars ($600.00) or more for up to a thirty (30) day supply;
- is not typically stocked at retail pharmacies; and
- requires:
  - a difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug; or
  - requires enhanced patient education, management, or support, beyond those required for traditional dispensing, or distribution of the drug.

"Complex or chronic medical condition" means a physical, behavioral, or developmental condition that:

1) may have no known cure;

2) is progressive; or

3) can be debilitation or fatal if left untreated or undertreated.

Complex or chronic medical conditions include: multiple sclerosis; hepatitis C; and rheumatoid arthritis.

"Rare medical condition" means a disease or condition that affects fewer than:

1) two hundred thousand (200,000) individuals in the United States; or

2) approximately one (1) in one thousand five hundred (1,500) individuals worldwide.

Rare medical conditions include cystic fibrosis; hemophilia; and multiple myeloma.

You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-DFS940 10-16

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

Therapeutic Alternative

A Prescription Drug Product or Medical Pharmaceutical that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

HC-DFS859 10-16

Therapeutic Equivalent

A Prescription Drug Product or Medical Pharmaceutical that is a pharmaceutical equivalent to another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

HC-DFS860 10-16

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

Usual and Customary (U&C) Charge

The usual fee that a Pharmacy charges individuals for a Prescription Drug Product (and any services related to the dispensing thereof) without reference to reimbursement to the Pharmacy by third parties. The Usual and Customary (U&C) Charge includes a dispensing fee and any applicable sales tax.

HC-DFS861 10-16

The following pages describe the features of your Cigna Choice Fund - Health Savings Account. Please read them carefully.

What You Should Know About Cigna Choice Fund® – Health Savings Account

Cigna Choice Fund is designed to give you:

Control

You decide how much you'd like to contribute (up to federal limits) to your Health Savings Account. You decide how and when to access your account. And the money in the account is yours until you spend it. Unused dollars remain in your account from year to year and earn interest.

Choice

You have the freedom to choose any licensed doctor, **even those who do not participate with** Cigna. Your costs are lower for services from Cigna contracted health care professionals and facilities because they have agreed to accept discounted payments to help you make the most of your health care dollars.

Easy Access to your HSA Dollars

You can draw money directly from your health savings account using your HSA debit card, checkbook (if purchased) or online bill pay. Or, you may choose automatic claim forwarding, which allows qualified medical claims to pay directly from your account to your doctor or hospital.

Flexibility and Tax Savings

You can also choose to pay for medical expenses out of your pocket until you reach the deductible, allowing you to save for qualified health care expenses in future years or retirement. You are not taxed on your HSA withdrawals unless you use the money to pay for nonqualified expenses.

Health Information and Education

Call the toll-free number on your ID card to reach Cigna's 24-Hour Health Information Line℠, giving you access to trained nurses and an audio library of health topics 24 hours a day. In addition, the Cigna Healthy Pregnancies, Healthy Babies® program provides prenatal education and support for mothers-to-be.

Tools & Support

We help you keep track of your health and coverage with online benefits information, transactions, and account activity; medical and drug cost comparisons; monthly statements; and more. You also have 24/7/365 toll-free access to a dedicated Customer Service team, specially trained to answer your questions and address your needs.

Savings on Health and Wellness Products and Services

Through Cigna Healthy Rewards®, you can save money on a variety of health-related products and services. Offerings include laser vision correction, acupuncture, chiropractic care, weight loss programs, fitness club and equipment discounts, and more.

The Basics

Who is eligible?

You are eligible to open a Health Savings Account only if you are covered under a federally qualified high deductible health plan, such as the one described in this booklet. You cannot be covered by Medicare or any other individual or group health plan that is not a federally qualified high deductible health plan. You can no longer contribute to the HSA once you: become entitled to Medicare due to age; or are no longer covered under a high deductible health plan. However, you will still be able to use the HSA funds for qualified health care expenses.

How does it work?

The Health Savings Account combines a health care plan with a tax-free savings account.

1. **You, your employer or both may contribute to your account.** Contributions are tax-free up to federal limits.
2. **You choose how to pay for qualified health care expenses:**
   - You may pay for qualified expenses on your own using a debit card, checkbook (if purchased) or online bill pay that draws from your health savings account.
   - You may choose the Automatic Claim Forwarding option, allowing qualifying medical expenses to be paid directly to your doctor, hospital, or other facility from your HSA. You can change your election at any time during the year.
   - You may choose to cover your expenses using other personal funds. This allows you to save the money in your HSA for qualified health care expenses in future years or at retirement. The balance in your savings account will earn interest.
3. **Once you meet your deductible, you and your plan share the costs**. Depending on your plan, you pay pre-determined coinsurance or copayments for certain services. Your employer determines the maximum amount of out-of-pocket expenses you pay each year. Once you meet the maximum, the plan pays covered expenses at 100%.

Your HSA can be a tax-sheltered savings tool. Because your HSA rolls over year after year, and unused money accumulates tax-deferred interest, you have the option to pay for current qualified health care expenses out of your pocket and use the account to save for future qualified expenses.

Please note: Your HSA contributions are not taxable under federal and most state laws. However, your contributions to

your HSA may be taxable as income in certain states. Please consult your tax advisor for guidance.

Which services are covered by my Cigna Choice Fund Health Savings Account?

Money in your HSA can be used only to cover qualified health care expenses for you and your dependents as allowed under federal tax law. In addition, your HSA may be used to cover COBRA continuation premiums, qualified long-term care insurance premiums, health plan premiums when you are receiving unemployment compensation, or Medicare or retiree health plan premiums (excluding Medicare Supplement or Medigap premiums) once you reach age 65. If you use your HSA funds for expenses that are not allowed under federal tax law, the withdrawal will be subject to tax, and you will incur a 20 percent tax penalty. The 20 percent penalty is not applicable once you reach age 65. A list of qualified health care expenses is available through www.myCigna.com.

Which services are covered by my Cigna medical plan, and which will I have to pay out of my own pocket?

Covered services vary depending on your plan, so visit www.myCigna.com or check your plan materials in this booklet for specific information. In addition to your monthly premiums deducted from your paycheck, you'll be responsible for paying:

- Any health care services not covered by your plan.
- Costs for any services you receive until you meet your deductible, if you choose not to use your health savings account, or after you spend all the money in your account.
- Your share of the cost for your covered health care expenses (coinsurance or copayments) after you meet the deductible and your medical plan coverage begins.

Tools and Resources at Your Fingertips

If you're not sure where to begin, you have access to health advocates.

You now have access to health specialists, including individuals trained as nurses, coaches, nutritionists and clinicians, who will listen, understand your needs and help you find solutions, even when you're not sure where to begin. Partner with a health coach and get help to maintain good eating and exercise habits; support and encouragement to set and reach health improvement goals; and guidance to better manage conditions, including coronary artery disease, low back pain, osteoarthritis, high blood pressure, high cholesterol and more. From quick answers to health questions to assistance with managing more serious health needs, call the toll-free number on your Cigna ID card or visit www.myCigna.com. See your benefits administrator for more details about all of the services you have access to through your plan.

Wherever you go in the U.S., you take the Cigna 24-Hour Health Information Line with you.

Whether it's late at night, or your child has a fever, or you're traveling and you're not sure where to get care, or you don't feel well and you're unsure about the symptoms, you can call the Cigna 24-Hour Health Information Line whenever you have a question. Call the toll-free number on your Cigna ID card and you will speak to a nurse who will help direct you to the appropriate care.

www.myCigna.com

www.myCigna.com provides fast, reliable and personalized information and service, including:

- Online access to your current account balance, past transactions and claim status, as well as your Explanation of Benefits and health statements.
- Medical cost and drug cost information, including cost estimates specific to you and your plan.
- Explanations of other Cigna products and services, what they are and how you can use them.
- Frequently asked questions about health care in general and Cigna Choice Fund specifically.
- A number of convenient, helpful tools that let you:

  Compare costs

  Use tools to compare costs and help you decide where to get care. You can compare out-of-pocket estimates, specific to your coverage plan, for actual treatment and procedures and costs.

  Find out more about your local hospitals

  Learn how hospitals rank by number of procedures performed, patients' average length of stay, and cost. Go to our online healthcare professional directory for estimated costs for certain procedures, including total charges and your out-of-pocket expense, based on your Cigna plan. You can also find hospitals that earn the Centers of Excellence designation based on effectiveness in treating selected procedures/conditions and cost.

  Get the facts about your medication, cost, treatment options and side effects

  Use the pharmacy tools to: check your prescription drug costs, listed by specific pharmacy and location (including Cigna Home Delivery Pharmacy); and review your claims history for the past 16 months. Look at condition-specific drug treatments and compare characteristics of more than 200 common medications. Evaluate up to 10 medications at once to better understand side effects, drug interactions and alternatives.

Take control of your health

Take the health assessment, an online questionnaire that can help you identify and monitor your health status. You can learn about preventive care and check your progress toward healthy goals. And if your results show that you may benefit from other services, you can learn about related Cigna programs on the same site.

Explore topics on medicine, health and wellness

Get information on more than 5,000 health conditions, health and wellness, first aid and medical exams through **Healthwise®** Medical Encyclopedia, an interactive library.

Keep track of your personal health information

Health Record is your central, secure location for your medical conditions, medications, allergies, surgeries, immunizations, and emergency contacts. You can add your health assessment results to **Health Record**, so you can easily print and share the information with your doctor. Your lab results from certain facilities can be automatically entered into your Personal Health Record.

Chart progress of important health indicators

Input key data such as blood pressure, blood sugar, cholesterol (Total/LDL/HDL), height and weight, and exercise regimen. **Health Tracker** makes it easy to chart the results and share them with your doctor.

Getting the Most from Your HSA

As a consumer, you make decisions every day, from buying the family car to choosing the breakfast cereal. Make yourself a more educated health care consumer and you'll find that you, too, can make a difference in the health care services you receive and what you ultimately pay.

If you choose to see a Cigna participating health care professional, the cost is based on discounted rates, so your costs will be lower. If you visit a health care professional or facility not in the network, you may still use your HSA to pay for the cost of those services, but you will pay a higher rate, and you may have to file claims.

If you need hospital care, there are several tools to help you make informed decisions about quality and cost.

- With the Hospital Comparison tool on www.myCigna.com, you can learn how hospitals rank by number of procedures performed, patients' average length of stay, and cost.
- Visit our healthcare professional directory for Cigna Centers of Excellence, providing hospital scores for specific procedures/conditions, such as cardiac care, hip and knee replacement, and bariatric surgery. Scores are based on cost and effectiveness in treating the procedure/condition, based on publicly available data.
- www.myCigna.com also includes a Healthcare Professional Excellence Recognition Directory. This directory includes information on:
  - Participating physicians who have achieved recognition from the National Committee for Quality Assurance (NCQA) for diabetes and/or heart and stroke care.
  - Hospitals that fully meet The Leapfrog Group patient safety standards.

A little knowledge goes a long way.

Getting the facts about your care, such as treatment options and health risks is important to your health and well-being, and your pocketbook. For instance:

- Getting appropriate preventive care is key to staying healthy. Visit www.myCigna.com to learn more about proper preventive care and what's covered under your plan.
- When it comes to medications, talk to your doctor about whether generic drugs are right for you. The brand-name drugs you are prescribed may have generic alternatives that could lower your costs. If a generic version of your brand-name drug is not available, other generic drugs with the same treatment effect may meet your needs.
- Tools on www.myCigna.com can help you take control of your health and health care spending. You can learn about medical topics and wellness, and keep track of your personal health information. You can also print personalized reports to discuss with your doctor.

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