# Millennium Health, LLC

OPEN ACCESS PLUS

**EFFECTIVE DATE: January 1, 2023**

CN062
3339798

This document printed in January, 2023 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: Millennium Health, LLC**

**GROUP POLICY(S)** — COVERAGE
3339798 - OAP2 OPEN ACCESS PLUS

**EFFECTIVE DATE:** January 1, 2023

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.

*Geneva Cambell Brown, 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 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.

HC-SPP63 01-20

**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.

HC-SPP2 04-10
V1

**Additional Programs**

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well being of our members. We may also arrange for the reimbursement of all or a portion of the cost of services

provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

HC-SPP3 04-10
V1

**Care Management and Care Coordination Services**

Cigna may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing participants with certain care management and care coordination services to facilitate achievement of these goals. Reimbursement is provided at 100% for these services when rendered by designated health care professionals in these collaborative arrangements.

HC-SPP27 06-15
V1

# Important Notices

**Direct Access to Obstetricians and Gynecologists**

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

**Selection of a Primary Care Provider**

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

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

HC-NOT5 01-11

**Important Information**

**Mental Health Parity and Addiction Equity Act**

**The Certificate is amended as stated below:**

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

**Visit Limits:**

Any health care service billed with a Mental Health or Substance Use Disorder diagnosis, will not incur a visit limit, including but not limited to genetic counseling.

HC-NOT93 08-17

**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 may 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.

If Cigna determines that a Pharmacy, pharmaceutical manufacturer or other third party is or has waived, reduced, or forgiven any portion of the charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Prescription Drug Product without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of plan benefits in connection with the Prescription Drug Product, 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 Pharmacy, pharmaceutical manufacturer or other third party 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 the plan.

For example, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a Prescription Drug Product, Cigna may, in its sole discretion, reduce the benefits up to the amount of the incentive, which may be 100% if the incentive covers 100%. This includes any amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party. The amount of the incentive will be excluded from accumulation toward any plan Deductible or Out-of-Pocket Maximum if the value of any coupon was applied to any Copayment, Deductible and/or Co-insurance you are required to pay.

HC-IMP267 08-19
V3

**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

**Special Plan Provisions**

**The Cigna 24-Hour Health Information Line**

The 24-Hour **Health Information Line** (HIL) assists you in understanding the right level of treatment at the right time. Trained Nurses provide health and medical information and assist you to choose the most appropriate care resource. Our Health Information Line Nurses identify level of care resources in the individual's area (emergency, urgent, Physician, home/self-care), provide general health information (preventive care, illness condition definitions, diagnostic and surgical procedures, etc.), and can help you find network providers. You can call the Health Information Line and get live support 24 hours a day, 7 days a week. Dial the number on the back of your Cigna ID card and you'll be connected directly to a Specialist trained as a Nurse who is ready to help answer your health questions.

**Appointment Scheduling**

You should have access to timely appointments and scheduling. The following guidelines represent both the plan's and the state of California's requirements for appointment accessibility with Participating Providers:

- Emergent or high risk cases should have access to immediate appointments, appropriate emergency room authorization or direction to dial 911.

- Urgent cases not requiring prior-authorization should have access to appointments within 24 hours of the appointment request.
- If services must be prior authorized, appointments should be offered concurrent with the prior authorization request and the appointment should be provided within 96 hours of the appointment request.
- Non-urgent, symptomatic or routine appointments with a PCP should be scheduled within 10 days of the appointment request.
- Non-urgent, symptomatic or routine appointments with a Specialist should be scheduled within 15 days of the appointment request.
- Preventive screenings and physicals should be scheduled within 30 days of the appointment request.
- Non-urgent appointments for ancillary services for the diagnosis or treatment of Injury or Sickness, or other health condition should be scheduled within 15 days of the appointment request.
- Non-urgent appointments with a non-Physician mental health care provider should be scheduled within 10 business days of the appointment request.
- Average waiting time in the office should not exceed 30 minutes.
- When it is necessary for you or a health care professional to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for your health care needs, and ensures continuity of care consistent with good professional practice.
- The applicable waiting time for a particular appointment may be extended if the referring or treating provider, or the health professional providing triage or screening services, has determined and noted in the relevant record that a longer wait time will not have a detrimental impact on your health.

**Accessing Health Care**

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

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

**Calling within California: 1-800-927-4357**

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

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

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

**Participating Providers**

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

**Service Area**

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

**Away From Home Care**

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

**Emergency Services**

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

To contact the Department of Insurance, write or call:

Consumer Affairs Division
California Department of Insurance
Ronald Reagan Building
300 South Spring Street
Los Angeles, CA 90013
Calling within California: 1-800-927-4357
Los Angeles Area and Outside California: 1-213-897-8921

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

**Your Rights Under HIPAA If You Lose Group Coverage**

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

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

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

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

**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 also does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation age or disability.

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 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, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation age or disability, you can file a grievance by sending an email to the Nondiscrimination Complaint Coordinator at ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422
You may also call the number on the back of your ID card or 1-800-244-6224
Fax: 866-254-9406

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, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

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

HC-IMP241 06-18

V1

## How To File Your Claim

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

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

**CLAIM REMINDERS**

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

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

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

**Timely Filing of Out-of-Network Claims**

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

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

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

## Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

**Effective Date of Dependent Insurance**

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

**Late Entrant – Dependent**

You are a Late Entrant for Dependent Insurance if:

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

**Exception for Newborns and Adopted Children**

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



# 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.

Direct Access for OB/GYN Services:

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

Direct Access for Treatment of Certain Reproductive and Sexual Health Care Services

Insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for covered reproductive and sexual health care services. There is no requirement to obtain an authorization from your Primary Care Physician for visits to the Participating Provider of your choice for:

- care related to the prevention or treatment of pregnancy, including sterilization and abortion;

- diagnosis or treatment related to an infectious, contagious or communicable disease, including public health conditions and sexually transmitted diseases;
- diagnosis and treatment related to rape, including the collection of medical evidence;
- diagnosis and treatment for sexual assault, including the collection of medical evidence with regard to the alleged sexual assault; and
- diagnosis and treatment for HIV and other tests.

Direct Access for Mental Health and Substance Use Disorder Services:

Insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for covered mental health and substance use disorder services. There is no requirement to obtain an authorization from your Primary Care Physician for individual or group therapy visits to a Participating Provider for mental health and substance use disorder services.

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# Open Access Plus Medical Benefits

## The Schedule

**For You and Your Dependents**

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

If you are unable to locate, or you do not have timely access to, an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you may use an Out-of-Network Provider. If you call the number on the back of your I.D. card to obtain assistance with your Out-of-Network Provider coverage, Cigna may negotiate Out-of-Network billed charges on your behalf with the Out-of-Network Provider. If you contact Cigna and do obtain authorization for services provided by an Out-of-Network Provider, Cigna will arrange for those services and benefits for those services will be covered at the In-Network benefit level. Otherwise, they may be covered at an Out-of-Network cost share.

If you receive a covered service at an In-Network health facility but from a non-Participating Provider who is licensed in California, you only have to pay the In-Network cost share amount shown in The Schedule. An In-Network "health facility" includes, but is not limited to, a licensed hospital, ambulatory surgery center, or other outpatient setting such as a lab, or a radiology or imaging center. At the time that Cigna reimburses the non-Participating Provider for the services provided, Cigna will inform you of any In-Network cost-sharing amount you may owe. Any In-Network cost sharing will be applied toward the In-Network Deductible and Out-of-Pocket maximum.
In certain situations, you may voluntarily choose to pay a non-Participating Provider at the Out-of-Network cost share. If you and the non-Participating Provider agree to this arrangement, the non-Participating Provider must receive your written authorization at least 24 hours in advance of providing service. The non-Participating Provider must also submit a copy of such authorization with the request for reimbursement.

**Coinsurance**

The term Coinsurance means the percentage of Covered Expenses that an insured person is required to pay under the plan in addition to the Deductible, if any.

**Copayments/Deductibles**

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

**Out-of-Pocket Expenses - For In-Network Charges Only**

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in The Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

# Open Access Plus Medical Benefits

## The Schedule

**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 copayments and/or 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 accumulate in one direction (that is, Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.

**Multiple Surgical Reduction**

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

**Assistant Surgeon and Co-Surgeon Charges**

**Assistant Surgeon**

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

**Co-Surgeon**

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

**Out-of-Network Emergency Services Charges**

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

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

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Lifetime Maximum** | Unlimited | |
| **The Percentage of Covered Expenses the Plan Pays** | 80% | 60% of the Maximum Reimbursable Charge |
| **Maximum Reimbursable Charge**<br>Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or<br>A policyholder-selected percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:<br>• the provider's normal charge for a similar service or supply; or<br>• the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. 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. | Not Applicable | 110% |
| **Note:**<br>The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance. | | |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Calendar Year Deductible** | | |
| Individual | $1,000 per person | $2,000 per person |
| Family Maximum | $2,000 per family | $4,000 per family |
| Family Maximum Calculation **Individual Calculation:** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance. | | |
| **Out-of-Pocket Maximum** | | |
| Individual | $4,750 per person | $9,500 per person |
| Family Maximum | $9,500 per family | $19,000 per family |
| Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%. | | |
| **Combined Medical/Pharmacy Out-of-Pocket Maximum** | | |
| Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery drugs | Yes | No |
| Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum | Yes | In-Network coverage only |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Physician's Services** | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Consultant and Referral Physician's Services | | |
| **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna on an In-Network basis. Out-of-Network OB/GYN providers will be considered a Specialist. | | |
| Surgery Performed in the Physician's Office | | |
| Primary Care Physician | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Second Opinion Consultations (provided on a voluntary basis) | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Allergy Treatment/Injections | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Allergy Serum (dispensed by the Physician in the office) | | |
| Primary Care Physician | 100% | Plan deductible, then 60% |
| Specialty Care Physician | 100% | Plan deductible, then 60% |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Virtual Care** | | |
| **Dedicated Virtual Providers** | | |
| Services available through contracted virtual providers as medically appropriate. | | |
| Virtual Care Services for minor medical conditions | $25 per visit copay, then 100% | In-Network coverage only |
| Virtual Wellness Screenings | 100% | In-Network coverage only |
| **Virtual Physician Services** | | |
| Services available through Physicians as medically appropriate. | | |
| **Note:** Preventive services covered at the preventive level. | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| **Preventive Care** | | |
| Routine Preventive Care (for children through age 16) | | |
| Primary Care Physician's Office Visit | 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | 100% | Plan deductible, then 60% |
| Immunizations (for children through age 16) | | |
| Primary Care Physician's Office Visit | 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | 100% | Plan deductible, then 60% |
| Routine Preventive Care (for ages 17 and over) | 100% | In-Network coverage only |
| Immunizations (for ages 17 and over) | 100% | In-Network coverage only |
| **Mammograms, PSA, PAP Smear** | | |
| Preventive Care Related Services (i.e. "routine" services) | 100% | Subject to the plan's x-ray benefit & lab benefit; based on place of service |
| Diagnostic Related Services (i.e. "non-routine" services) | Subject to the plan's x-ray benefit & lab benefit; based on place of service | Subject to the plan's x-ray benefit & lab benefit; based on place of service |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Inpatient Hospital - Facility Services** | $100 per admission copay, then plan deductible, then 80% | Plan deductible, then 60% |
| **Bed and Board Limit** | | |
| Semi-Private Room | 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 | Plan deductible, then 80% | Plan deductible, then 60% |
| **Inpatient Hospital Physician's Visits/Consultations** | Plan deductible, then 80% | Plan deductible, then 60% |
| **Inpatient Professional Services** | Plan deductible, then 80% | Plan deductible, then 60% |
| Surgeon | | |
| Radiologist, Pathologist, Anesthesiologist | | |
| **Outpatient Professional Services** | Plan deductible, then 80% | Plan deductible, then 60% |
| Surgeon | | |
| Radiologist, Pathologist, Anesthesiologist | | |
| **Urgent Care Services** | | |
| Urgent Care Facility or Outpatient Facility | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the UC visit. | | |
| Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the UC visit | $25 per visit copay, then 100% | Plan deductible, then 60% |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Emergency Services** | | |
| Hospital Emergency Room<br>Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. | $100 per visit copay (waived if admitted), then 100% | $100 per visit copay (waived if admitted), then 100% |
| Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER visit | $100 per visit copay (waived if admitted), then 100% | $100 per visit copay (waived if admitted), then 100% |
| **Ambulance** | Plan deductible, then 80% | Plan deductible, then 80% |
| **Inpatient Services at Other Health Care Facilities**<br>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities<br>Calendar Year Maximum: 100 days combined | Plan deductible, then 80% | Plan deductible, then 60% |
| **Laboratory Services** | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Outpatient Hospital Facility | Plan deductible, then 80% | Plan deductible, then 60% |
| Independent Lab Facility | Plan deductible, then 80% | Plan deductible, then 60% |
| **Radiology Services** | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Outpatient Hospital Facility | Plan deductible, then 80% | Plan deductible, then 60% |
| **Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)** | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Inpatient Facility | $100 per admission copay, then plan deductible, then 80% | Plan deductible, then 60% |
| Outpatient Facility | Plan deductible, then 80% | Plan deductible, then 60% |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Outpatient Therapy Services**<br>Calendar Year Maximum:<br>Unlimited<br>Includes:<br>Physical Therapy<br>Speech Therapy<br>Occupational Therapy<br>Pulmonary Rehab<br>Cognitive Therapy | | |
| Primary Care Physician's Office Visit | $25 per visit copay*, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay*, then 100%<br>***Note:**<br>Outpatient Therapy Services copay applies, regardless of place of service, including the home. | Plan deductible, then 60% |
| **Outpatient Cardiac Rehabilitation**<br>Calendar Year Maximum:<br>Unlimited | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| **Chiropractic Care**<br>Calendar Year Maximum:<br>20 days | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| **Acupuncture**<br>Calendar Year Maximum:<br>20 days | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Home Health Care Services** | | |
| Calendar Year Maximum:<br>100 days (includes outpatient private nursing when approved as Medically Necessary)<br>(The limit is not applicable to Mental Health and Substance Use Disorder conditions.) | Plan deductible, then 80% | Plan deductible, then 60% |
| **Hospice** | | |
| Inpatient Services | Plan deductible, then 80% | Plan deductible, then 60% |
| Outpatient Services<br>(same coinsurance level as Home Health Care Services) | Plan deductible, then 80% | Plan deductible, then 60% |
| **Bereavement Counseling** | | |
| Services provided as part of Hospice Care | | |
| Inpatient | Plan deductible, then 80% | Plan deductible, then 60% |
| Outpatient | Plan deductible, then 80% | Plan deductible, then 60% |
| Services provided by Mental Health Professional | Covered under Mental Health benefit | Covered under Mental Health benefit |
| **Medical Pharmaceuticals** | | |
| Physician's Office | 100% | Plan deductible, then 60% |
| Home Care | Plan deductible, then 80% | Plan deductible, then 60% |
| Inpatient Facility | Plan deductible, then 80% | Plan deductible, then 60% |
| Outpatient Facility | Plan deductible, then 80% | Plan deductible, then 60% |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Gene Therapy**<br>Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary.<br>Gene therapy must be received at an In-Network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other In-Network facilities is not covered. | | |
| Gene Therapy Product | Covered same as Medical Pharmaceuticals | In-Network coverage only |
| Inpatient Facility | $100 per admission copay, then plan deductible, then 80% | In-Network coverage only |
| Outpatient Facility | Plan deductible, then 80% | In-Network coverage only |
| Inpatient Professional Services | Plan deductible, then 80% | In-Network coverage only |
| Outpatient Professional Services | Plan deductible, then 80% | In-Network coverage only |
| Travel Maximum:<br>$10,000 per episode of gene therapy | 100% (available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy) | In-Network coverage only |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Maternity Care Services** | | |
| Initial Visit to Confirm Pregnancy | | |
| **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna on an In-Network basis. Out-of-Network OB/GYN providers will be considered a Specialist. | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee) | Plan deductible, then 80% | Plan deductible, then 60% |
| Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Delivery - Facility (Inpatient Hospital, Birthing Center) | $100 per admission copay, then plan deductible, then 80% | Plan deductible, then 60% |
| **Abortion** | | |
| Includes elective and non-elective procedures | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Inpatient Facility | $100 per admission copay, then plan deductible, then 80% | Plan deductible, then 60% |
| Outpatient Facility | Plan deductible, then 80% | Plan deductible, then 60% |
| Inpatient Professional Services | Plan deductible, then 80% | Plan deductible, then 60% |
| Outpatient Professional Services | Plan deductible, then 80% | Plan deductible, then 60% |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Women's Family Planning Services** | | |
| Office Visits, Lab and Radiology Tests and Counseling | | |
| **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. | | |
| Primary Care Physician | 100% | Plan deductible, then 60% |
| Specialty Care Physician | 100% | Plan deductible, then 60% |
| Surgical Sterilization Procedures for Tubal Ligation (excludes reversals) | | |
| Primary Care Physician's Office Visit | 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | 100% | Plan deductible, then 60% |
| Inpatient Facility | 100% | Plan deductible, then 60% |
| Outpatient Facility | 100% | Plan deductible, then 60% |
| Inpatient Professional Services | 100% | Plan deductible, then 60% |
| Outpatient Professional Services | 100% | Plan deductible, then 60% |
| **Men's Family Planning Services** | | |
| Office Visits, Lab and Radiology Tests and Counseling | | |
| Primary Care Physician | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Surgical Sterilization Procedures for Vasectomy (excludes reversals) | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Inpatient Facility | $100 per admission copay, then plan deductible, then 80% | Plan deductible, then 60% |
| Outpatient Facility | Plan deductible, then 80% | Plan deductible, then 60% |
| Inpatient Professional Services | Plan deductible, then 80% | Plan deductible, then 60% |
| Outpatient Professional Services | Plan deductible, then 80% | Plan deductible, then 60% |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Infertility Treatment**<br>Services Not Covered include:<br>• Testing performed specifically to determine the cause of infertility.<br>• Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).<br>• Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).<br>**Note:**<br>Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness. | Not Covered | Not Covered |
| **Organ Transplants**<br>Includes all medically appropriate, non-experimental transplants | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | In-Network coverage only |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | In-Network coverage only |
| Inpatient Facility | $100 per admission copay, then 100% at LifeSOURCE center, otherwise $100 per admission copay, then plan deductible, then 80% | In-Network coverage only |
| Inpatient Professional Services | 100% at LifeSOURCE center, otherwise plan deductible, then 80% | In-Network coverage only |
| Lifetime Travel Maximum: $10,000 per transplant | 100% (only available when using LifeSOURCE facility) | In-Network coverage only |
| **Durable Medical Equipment**<br>Calendar Year Maximum: Unlimited | Plan deductible, then 80% | Plan deductible, then 60% |
| **External Prosthetic Appliances**<br>Calendar Year Maximum: Unlimited | Plan deductible, then 80% | Plan deductible, then 60% |
| **Diabetic Equipment**<br>Calendar Year Maximum: Unlimited | Plan deductible, then 80% | Plan deductible, then 60% |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Nutritional Counseling** | | |
| 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. | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Inpatient Facility | $100 per admission copay, then plan deductible, then 80% | Plan deductible, then 60% |
| Outpatient Facility | Plan deductible, then 80% | Plan deductible, then 60% |
| Inpatient Professional Services | Plan deductible, then 80% | Plan deductible, then 60% |
| Outpatient Professional Services | Plan deductible, then 80% | Plan deductible, then 60% |
| **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. | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Inpatient Facility | $100 per admission copay, then plan deductible, then 80% | Plan deductible, then 60% |
| Outpatient Facility | Plan deductible, then 80% | Plan deductible, then 60% |
| Inpatient Professional Services | Plan deductible, then 80% | Plan deductible, then 60% |
| Outpatient Professional Services | Plan deductible, then 80% | Plan deductible, then 60% |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Dental Care**<br>Limited to charges made for a continuous course of dental treatment started within six months of an injury to teeth. | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | Plan deductible, then 60% |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Inpatient Facility | $100 per admission copay, then plan deductible, then 80% | Plan deductible, then 60% |
| Outpatient Facility | Plan deductible, then 80% | Plan deductible, then 60% |
| Inpatient Professional Services | Plan deductible, then 80% | Plan deductible, then 60% |
| Outpatient Professional Services | Plan deductible, then 80% | Plan deductible, then 60% |
| **Obesity/Bariatric Surgery**<br>**Note:**<br>Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate. | | |
| Primary Care Physician's Office Visit | $25 per visit copay, then 100% | In-Network coverage only |
| Specialty Care Physician's Office Visit | $40 per visit copay, then 100% | In-Network coverage only |
| Inpatient Facility | $100 per admission copay, then plan deductible, then 80% | In-Network coverage only |
| Outpatient Facility | Plan deductible, then 80% | In-Network coverage only |
| Inpatient Professional Services | Plan deductible, then 80% | In-Network coverage only |
| Outpatient Professional Services | Plan deductible, then 80% | In-Network coverage only |
| Surgical Professional Services<br>Lifetime Maximum:<br>Unlimited<br><br>**Notes:**<br>• Includes charges for surgeon only; does not include radiologist, anesthesiologist, etc.<br>• Does not accumulate to the Out-of-Pocket Maximum.<br>• Only surgical services accumulate to the maximum. | | |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Routine Foot Disorders** | Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary. | Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary. |
| **Treatment Resulting From Life Threatening Emergencies**<br>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. | | |
| **Mental Health** | | |
| **Inpatient**<br>Includes Acute Inpatient and Residential Treatment<br><br>Calendar Year Maximum: Unlimited | $100 per admission copay, then plan deductible, then 80% | Plan deductible, then 60% |
| **Outpatient** | | |
| Outpatient - Office Visits<br>Includes individual, family and group psychotherapy; medication management, virtual care, etc.<br><br>Calendar Year Maximum: Unlimited | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Outpatient - All Other Services<br>Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc.<br><br>Includes coverage for Applied Behavioral Analysis (ABA) for the treatment of autism.<br><br>Calendar Year Maximum: Unlimited | Plan deductible, then 80% | Plan deductible, then 60% |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Substance Use Disorder** | | |
| **Inpatient**<br>Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment<br><br>Calendar Year Maximum: Unlimited | $100 per admission copay, then plan deductible, then 80% | Plan deductible, then 60% |
| **Outpatient** | | |
| Outpatient - Office Visits<br><br>Includes individual, family and group psychotherapy; medication management, virtual care, etc.<br><br>Calendar Year Maximum: Unlimited | $40 per visit copay, then 100% | Plan deductible, then 60% |
| Outpatient - All Other Services<br><br>Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc.<br><br>Calendar Year Maximum: Unlimited | Plan deductible, then 80% | Plan deductible, then 60% |

# 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 Mental Health or Substance Use Disorder Residential Treatment Services.

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

Covered Expenses incurred will be reduced by 50% for Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

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

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

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

**Outpatient Certification Requirements – Out-of-Network**

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

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

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or outpatient procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

**Outpatient Diagnostic Testing and Outpatient Procedures**

Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Home Health Care Services.
- Durable medical equipment.
- External prosthetics.
- Medical Pharmaceuticals.
- Radiation therapy.

**Continuity of Care**

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

- **an acute condition**. An acute condition is a medical condition that involves a sudden onset of symptoms due to

an illness, Injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

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

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

Cigna is not obligated to arrange for continuity of care with a terminated Participating Provider or non-Participating Provider who has been terminated for medical disciplinary reasons or who has committed fraud or other criminal activities.

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

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

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

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

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## 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 are covered services in the following categories:

- inpatient Hospital services, except for 48/96 hour maternity stays;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- outpatient facility services;

- partial hospitalizations;
- advanced radiological imaging;
- non-emergency Ambulance;
- certain Medical Pharmaceuticals;
- transplant services;
- speech, occupational and physical therapy;
- Applied Behavior Analysis (ABA);
- infertility services;
- durable medical equipment;
- Home Health Care Services;
- home infusion services;
- back/spine procedures;
- ear devices;
- oral pharynx procedures;
- orthotics and prosthetics;
- radiation therapy;
- sleep management; genetic testing; or
- musculoskeletal pain management services.

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## Covered Expenses

The term Covered Expenses means expenses incurred by a person while covered under this plan for the charges listed below for:

- preventive care services, and
- services or supplies that are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna.

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

**Covered Expenses**

- charges for inpatient Room and Board and other Necessary Services and Supplies; made by a Hospital; subject to the limits as shown in The Schedule.
- charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
- charges for outpatient medical care and treatment received at a Hospital.
- charges for outpatient medical care and treatment received at a Free-Standing Surgical Facility.
- charges for Emergency Services.
- charges for Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse for professional nursing service.
- charges made for anesthetics, including, but not limited to supplies and their administration.
- charges for diagnostic x-ray.
- charges for advanced radiological imaging, including for example:
  - CT Scans, MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.
- charges for chemotherapy.
- charges for blood transfusions.
- charges for oxygen and other gases and their administration.
- charges made for Medically Necessary foot care for diabetes, peripheral neuropathies and peripheral vascular disease.
- charges made for or in connection with mammograms for breast cancer screenings or diagnostic purposes including, but not limited to: a baseline mammogram for women age 35, but less than 40; a mammogram for women age 40, but less than 50, every two years or more, if Medically Necessary and if recommended by a Physician, nurse practitioner or a nurse midwife; and a mammogram every year for women age 50 and over.
- charges made for an annual Papanicolaou laboratory screening test.
- charges for the screening and diagnosis of prostate cancer, including, but not limited to, Medically Necessary prostate-specific antigen (PSA) testing and digital rectal examinations.
- charges made for services related to the diagnosis, treatment, and management of osteoporosis. Covered services include, but are not limited to, all FDA approved technologies, including bone mass measurement technologies as deemed Medically Necessary.
- charges made for expenses incurred at any of the Approximate Age Intervals shown below for a Dependent child who is age 16 or less, for charges made for Child Preventive Care consisting of the following services

delivered or supervised by a Physician, in keeping with prevailing medical standards:

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

excluding any charges for:

- more than one visit to one provider for Child Preventive Care Services at each of the Appropriate Age Intervals up to a total of 18 visits for each Dependent child;
- services for which benefits are otherwise provided under this Covered Expenses section; or
- services for which benefits are not payable according to the "Expenses Not Covered" section.

Approximate Age Intervals are: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years and 16 years.

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

**Dedicated Virtual Providers**

- charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video and secure internet-based technologies.

**Virtual Physician Services**

- charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.
- Includes charges made for telehealth services on the same basis, or better, and to the same extent, or better, as the same service through in-person diagnosis, consultation, or treatment. Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the Provider for telehealth is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes:
  - Synchronous Interactions: Synchronous Interaction means a real-time interaction between a patient and a Health Care Provider for telehealth located at a distant site; and
  - Asynchronous Store and Forward transfers: Asynchronous Store and Forward means the transmission of a patient's medical information from an originating site to the health care provider for telehealth at a distant site without the presence of the patient.

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

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

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

  Formula means an enteral product used in the home and prescribed by a Physician, nurse practitioner, or registered dietician for Medically Necessary treatment of PKU. Special food products are those that are prescribed by a Physician or Nurse practitioner for the treatment of PKU and are consistent with the recommendations and best practices of qualified health professionals with expertise in treatment and care of PKU. It does not include a food that is naturally low in protein. It may include a food product that is specially formulated to have less than one gram of protein per serving and is used instead of normal food products used by the general population, such as grocery store foods.
- charges made for Medically Necessary treatment of Severe Mental Illness for covered persons of any age, and Serious Emotional Disturbances of a Dependent Child under 18 years old.
- charges made for prosthetic appliances, including devices to restore a method of speaking following a laryngectomy, other than electronic voice-producing machines.
- charges made by a licensed social worker, a registered Nurse licensed in psychiatric-mental health or a licensed marriage, family or child counselor, for Mental Health services, when such services are recommended by a Physician.
- charges for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following a cesarean section for both mother and newborn. The mother and/or newborn may be discharged earlier if the Physician consults with the mother. If discharged early, there will be at least one follow-up visit within 48 hours of discharge. Follow-up care may be in the mother's home, in the Physician's office, or in a licensed facility. An additional

length of stay beyond the 48/96 hours will be covered if Medically Necessary.

The following describes coverage provided for the treatment of diabetes:

- charges for the following Medically Necessary equipment for the management and treatment of insulin-using diabetes, noninsulin-using diabetes, and gestational diabetes: blood glucose monitors; blood glucose monitors designed to assist the visually impaired; insulin pumps and all related necessary supplies; podiatric devices to prevent or treat diabetes-related complications; and visual aids (not including eyewear) to assist the visually impaired with proper dosing of insulin.
- charges for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to allow a covered person to properly use the equipment, supplies, and medications listed previously, and any additional diabetes outpatient self-management training, education, and medical nutrition therapy prescribed by or directed by a Physician.
- charges for insulin, insulin syringes, Prescriptive medications for the treatment of diabetes, lancets and lancet puncture devices, blood glucose testing strips, ketone urine testing strips, pen delivery systems for the administration of insulin and Glucagon.
- charges for cancer screening tests that are based on generally accepted medical guidelines or scientific evidence.
- charges for prenatal testing resulting from participation in the Expanded Alpha Feto Protein program administered by the State Department of Health Services. No Cost share
- charges for general anesthesia and associated facility charges for dental procedures rendered in a Hospital or Ambulatory Surgical Facility for: a child under the age of 7; an individual who is developmentally disabled; or an individual whose health is compromised and general anesthesia is Medically Necessary.
- charges for a Hospital stay resulting from a mastectomy and/or lymph node dissection for a period of time determined by a Physician in consultation with the patient.
- charges made for a drug that has been prescribed for purposes other than those approved by the FDA will be covered if:
  - the drug is otherwise approved by the FDA;
  - the drug is used to treat a life-threatening condition or, a chronic and seriously debilitating condition and the drug is Medically Necessary to treat that condition;
  - the drug has been recognized for the treatment prescribed by any of the following: the American Hospital Formulary Service Drug Information, one of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology; The National Comprehensive Cancer Network Drug and Biologics compendium; The Thomson Micromedix Drug Dex; or two articles from major peer reviewed medical journals that present data supporting the proposed use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

**Second Opinions**

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

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

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

**Appropriately Qualified Health Care Professional**

An Appropriately Qualified Health Care Professional is a Primary Care Physician or Specialist who is acting within his/her scope of practice and who possesses a clinical

background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

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

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

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

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

- charges for the treatment of nicotine use.
- 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).
- FDA-approved, self-administered hormonal contraceptives will be covered for up to a 12-month supply when dispensed at one time.
- Alternate methods of contraception, including over-the-counter contraceptive drugs as prescribed by a Physician and deemed Medically Necessary.
- charges made for preventive care services as defined by recommendations from the following:
  - The U.S. Preventive Services Task Force (A and B recommendations);
  - The Advisory Committee on Immunization Practices (ACIP) for immunizations;
  - The American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;
  - The Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
  - With respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.

  Detailed information is available at www.healthcare.gov. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.
- charges made for surgical or non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- charges for federal Food and Drug Administration (FDA)-approved prescription contraceptive methods, as designated by Cigna. If your Physician determines that none of the methods designated by Cigna are medically appropriate for you because of your medical or personal history, Cigna will cover the alternative FDA-approved prescription contraceptive prescribed by your Physician.
- charges made for acupuncture services involving the stimulation of specific anatomical locations on the skin through the penetration of fine needles, for the purpose of relieving pain or treating disease as Medically Necessary.

**Autism Spectrum Disorder**

Covered expenses are professional services and treatment programs, including applied behavior analysis (ABA), and evidence-based behavior intervention programs that develop or restore to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism provided that:

- The treatment is prescribed by a licensed Physician or is developed by a licensed psychologist.
- The treatment is provided under a treatment plan prescribed by a qualified autism service provider.
- The treatment plan has measurable goals over a specific time-line that is developed and approved by the qualified autism service provider for the specific patient being treated.
- The treatment plan is not used for purposes of providing/reimbursing respite care, day care or educational services and is not used to reimburse a parent for participating in the treatment program.

**Telecommunication Technologies - Mental Health and Substance Use Disorder**

- behavioral consultations and services via secure telecommunications technologies that shall include video

capability, including telephones and internet, when delivered through a behavioral provider.

**Nutritional Counseling**

Charges for counseling when diet is a part of the medical management of a medical or behavioral condition.

**Internal Prosthetic/Medical Appliances**

Charges 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.

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**Obesity Treatment**

- charges made for medical and surgical services only at approved centers for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer reviewed, evidence based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities. The following items are specifically excluded:
  - medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity; and
  - weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

HC-COV2 04-10
V1

**Home Health Services**

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

  Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

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

HC-COV76 04-10
V1

**Hospice Care Services**

- charges 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 Room and Board and Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;

- charges for physical, occupational and speech therapy;
- charges for medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living.

HC-COV994 01-20

**Mental Health and Substance Abuse Services**

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

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

**Inpatient Mental Health Services**

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

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

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

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

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

**Outpatient Mental Health Services**

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

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

**Inpatient Substance Abuse Rehabilitation Services**

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

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

**Substance Abuse Residential Treatment Services** are services provided by a Hospital for the evaluation and treatment of the psychological and social functional

disturbances that are a result of subacute Substance Abuse conditions.

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

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

**Outpatient Substance Abuse Rehabilitation Services**

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

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

**Substance Abuse Detoxification Services**

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

**Exclusions**

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

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

HC-COV7 04-10
V4

**Durable Medical Equipment**

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

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

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

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

lifts are covered if patient is two-person transfer), and auto tilt chairs.

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

HC-COV8 04-10
V2

**External Prosthetic Appliances and Devices**

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect.

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

**Prostheses/Prosthetic Appliances and Devices**

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

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

**Orthoses and Orthotic Devices**

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

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid 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;
- non-foot orthoses primarily used for cosmetic rather than functional reasons; and
- non-foot orthoses primarily for improved athletic performance or sports participation.

**Braces**

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

The following braces are specifically excluded: Copes scoliosis braces.

**Splints**

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

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

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

- replacement required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- replacement due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited as follows:

- no more than once every 24 months for persons 19 years of age and older.
- no more than once every 12 months for persons 18 years of age and under.

The following are specifically excluded external prosthetic appliances and devices:

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

HC-COV890 01-20

**Outpatient Therapy Services**

Charges for the following therapy services:

**Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy**

- Charges for therapy services are covered when provided as part of a program of treatment.

**Cardiac Rehabilitation**

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

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

**Chiropractic Care Services**

- Charges 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.

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

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

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

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

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

Therapy services that are not covered include:

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

Coverage is administered according to the following:

- Multiple therapy services provided on the same day constitute one day of service for each therapy type.
- A separate Copayment applies to the services provided by each provider for each therapy type per day.

HC-COV887 01-20
V1

**Breast Reconstruction and Breast Prostheses**

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

**Reconstructive Surgery**

- charges made for reconstructive surgery or therapy to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function; or 2) to create normal appearance, to the extent possible. Reconstructive Surgery also includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate means a condition that may include cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

HC-COV728 08-18

**Transplant Services**

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

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

All Transplant services, other than cornea, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are not covered.

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

**Transplant Travel Services**

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

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses: travel costs incurred due to travel within 60 miles of your home; laundry bills;

telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

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

HC-COV15 04-10
V2

**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-COV553 10-16

**Gene Therapy**

Charges for gene therapy products and services directly related to their administration are covered when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when prior authorized to be received at In-Network facilities specifically contracted with Cigna for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered.

**Gene Therapy Travel Services**

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy; and when the gene therapy products and services directly related to their administration are received at a participating In-Network facility specifically contracted with Cigna for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

HC-COV886 01-20

**Clinical Trials**

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

- 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; or
- the individual provides medical and scientific information establishing that the individual's participation in the qualified trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered.

The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that meets **any** of the following criteria:

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH).
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Health Care Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).
  - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
- any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:
  - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
  - the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The plan does not cover any of the following services associated with a clinical trial:

- services that are not considered routine patient care costs and services, including the following:
  - the investigational drug, device, item, or service that is provided solely to satisfy data collection and analysis needs.
  - an item or service that is not used in the direct clinical management of the individual.
  - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- an item or service provided by the research sponsors free of charge for any person enrolled in the trial.
- travel and transportation expenses, unless otherwise covered under the plan, including but not limited to the following:
  - fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train.
  - mileage reimbursement for driving a personal vehicle.
  - lodging.
  - meals.
- routine patient costs obtained out-of-network when Out-of-Network benefits do not exist under the plan.

Examples of routine patient care costs and services include:

- radiological services.
- laboratory services.
- intravenous therapy.

- anesthesia services.
- Physician services.
- office services.
- Hospital services.
- Room and Board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

Clinical trials conducted by Out-of-Network providers will be covered only when the following conditions are met:

- In-Network providers are not participating in the clinical trial; or
- The clinical trial is conducted outside the individual's state of residence.

HC-COV884 01-20

# 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.

**Coinsurance**

The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.

**Copayments (Copay)**

Copayments are amounts 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 Network Pharmacies at 100% with no deductible and if applicable at non-Network Pharmacies, the same as the out of network medical cost share for injectable/IV chemotherapy.

| BENEFIT HIGHLIGHTS | NETWORK PHARMACY | NON-NETWORK PHARMACY |
|---|---|---|
| **Lifetime Maximum** | Refer to the Medical Benefits Schedule | Refer to the Medical Benefits Schedule |

| BENEFIT HIGHLIGHTS | NETWORK PHARMACY | NON-NETWORK PHARMACY |
|---|---|---|
| **Patient Assurance Program**<br>Your plan offers additional discounts for certain covered Prescription Drug Products that are dispensed by a retail or home delivery Network Pharmacy included in what is known as the "Patient Assurance Program". As may be described elsewhere in this plan, from time to time Cigna may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your Out-of-Pocket Expenses for certain covered Prescription Drug Products for which Cigna directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna for certain covered Prescription Drug Products included in the Patient Assurance Program is applied or credited to a portion of your Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drug Products as set forth in The Schedule may be reduced in order for Patient Assurance Program discounts earned by Cigna to be applied or credited to the Copayment or Coinsurance, if any, as described above.<br>For example, certain insulin product(s) covered under the Prescription Drug Benefit for which Cigna directly or indirectly earns a discount in connection with the Patient Assurance Program shall result in a credit toward some or all of your Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in The Schedule, for the insulin product. In addition, the covered insulin products eligible for Patient Assurance Program discounts shall not be subject to the Deductible, if any.<br>Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum.<br>Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum.<br>Please note that the Patient Assurance Program discounts that Cigna may earn for Prescription Drug Products, and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any rebates or other payments that Cigna may earn from a pharmaceutical manufacturer for the same or other Prescription Drug Products. Except as may be noted elsewhere in this plan, you are not entitled to the benefit of those rebates or other payments earned by Cigna because they are unrelated to the Patient Assurance Program. Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drug Products included in the Patient Assurance Program and/or your Copayment or Coinsurance, if any for those eligible Prescription Drug Products, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to Cigna in connection with the Patient Assurance Program. More information about the Patient Assurance Program including the Prescription Drug Products included in the program, is available at the website shown on your ID card or by calling member services at the telephone number on your ID card. | | |
| **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 |
| 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. | | |

| BENEFIT HIGHLIGHTS | NETWORK PHARMACY | NON-NETWORK PHARMACY |
|---|---|---|
| **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**<br>Generic Drugs on the Prescription Drug List | No charge after $15 Copay | In-network coverage only |
| **Tier 2**<br>Brand Drugs designated as preferred on the Prescription Drug List | No charge after $35 Copay | In-network coverage only |
| **Tier 3**<br>Brand Drugs designated as non-preferred on the Prescription Drug List | No charge after $60 Copay | In-network coverage only |
| **Tier 4**<br>Self-Administered Injectable Specialty Prescription Drug Products | 30% subject to a maximum of $200 Copay | In-network coverage only |
| **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** |
| Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill and are subject to the same Copayment or Coinsurance that applies to retail Pharmacies. | | |
| **Tier 1**<br>Generic Drugs on the Prescription Drug List | No charge after $30 Copay | In-network coverage only |
| **Tier 2**<br>Brand Drugs designated as preferred on the Prescription Drug List | No charge after $70 Copay | In-network coverage only |
| **Tier 3**<br>Brand Drugs designated as non-preferred on the Prescription Drug List | No charge after $120 Copay | In-network coverage only |

| BENEFIT HIGHLIGHTS | NETWORK PHARMACY | NON-NETWORK PHARMACY |
|---|---|---|
| **Tier 4** | | |
| Self-Administered Injectable Specialty Prescription Drug Products | Specialty Prescription Drug Products are limited to up to a consecutive 30 day supply per Prescription Order or Refill.<br>30% | In-network coverage only |

# Prescription Drug Benefits

## Covered Expenses

Your plan provides benefits for Prescription Drug Products dispensed by a Pharmacy. Details regarding your plan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations and Exclusions are provided below and/or 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, your plan 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.

For combination anti-retroviral drug treatments that are Medically Necessary for the treatment of AIDS/HIV, this plan covers a single-tablet drug regimen that is as effective as a multi-tablet regimen unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multi-tablet regimen is clinically equal or more effective and more likely to result in adherence to a drug regimen.

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 pursuant to the, as applicable, Copayment or Coinsurance for the Prescription Drug Product when dispensed by a 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. A copy of the formulary is available at www.cigna.com/prescription-drug-list or by calling the number on the back of your ID card.

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.

A Prescription Drug Product that is not on the Prescription Drug List may be covered if the Prescription Drug Product is determined to be Medically Necessary and your Physician obtains authorization for coverage of the non-Prescription Drug List Prescription Drug Product.

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## Limitations

In the event you or your Dependent insist on a more expensive Brand Drug where a Generic Drug is available, you will be

financially responsible for the amount by which the cost of the Brand Drug exceeds the cost of the Generic Drug, plus any required Brand Drug Copayment and/or Coinsurance. In this case, the amount by which the cost of the Brand Drug exceeds the cost of the Generic Drug will not apply to your Deductible, if any, or Out-of-Pocket Maximum. However, in the event your Physician determines that the Generic Drug is not an acceptable alternative for you (and indicates Dispensed as Written on the Prescription Order or Refill), you will only be responsible for payment of the appropriate Brand Drug Coinsurance and/or Copayment after satisfying your Deductible, if any.

**Contraceptives**

Additionally, in the event your Physician determines that a prescription contraceptive that would be payable at 100% is not a medically acceptable alternative for you, the applicable cost-share for a covered alternative contraceptive will be waived. Contact Cigna at the website or phone number on your ID card.

**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, you and your Physician will receive confirmation within 72 hours for non-urgent requests and within 24 hours for exigent requests. 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 within 72 hours for non-urgent requests and within 24 hours for exigent requests. 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. The appeal provisions, including the address for submitting an appeal, are outlined in the "When You Have A Complaint Or An Adverse Determination Appeal" section of your certificate. You may also call Customer Service at the toll-free number on your Identification Card if you have questions about the appeal process.

**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.In circumstances where you or your Dependent are changing policies, the new policy shall not require a repeat of step therapy when the insured is already being treated for a medical condition by a Prescription Drug Product that is appropriately prescribed and is considered safe and effective. The new policy can impose a prior authorization requirement for the continued coverage of a Prescription Drug Product prescribed pursuant to step therapy imposed by the former policy. A prescribing provider may prescribe another Prescription Drug Product covered by the new policy that is medically appropriate for the insured.

**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.

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.

FDA-approved, self-administered hormonal contraceptives will be covered for up to a 12-month supply when dispensed at one time.

**Specialty Prescription Drug Products**

Benefits are provided for Specialty Prescription Drug Products.

**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.

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## Your Payments

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

**Copayment**

Your plan requires that you pay a Copayment for covered Prescription Drug Products as set forth in The Schedule. After satisfying any applicable annual Deductible set forth in The Schedule, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy and that is subject to a Copayment requirement will be the lowest of the following amounts:

- the Copayment for the Prescription Drug Product set forth in The Schedule; or
- the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

**Coinsurance**

Your plan requires that you pay a Coinsurance amount for covered Prescription Drug Products as set forth in The Schedule. After satisfying any applicable annual Deductible set forth in The Schedule, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy and that is subject to a Coinsurance requirement will be the lowest of the following amounts:

- the amount that results from applying the applicable Coinsurance percentage set forth in The Schedule to the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

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

You will need to obtain prior approval from Cigna or its Review Organization for any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded. If Cigna or its Review Organization approves coverage for the Prescription Drug Product because it meets the applicable coverage exception criteria, the Prescription Drug Product 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.

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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 Prescription Drug List 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).
- 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.
- Prescription Drug Products used for the treatment of infertility.
- 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), and do not meet the definition of a Part D eligible drug.
- 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 unless specifically identified on the Prescription Drug List.
- smoking cessation medications except those required by federal law to be covered as Preventive Care Medications.
- 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 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 for a Prescription Drug Product obtained at a Network Pharmacy unless you pay the full cost of a Prescription Drug Product at a Network Pharmacy and later seek reimbursement for the Prescription Drug Product under the plan. For example, if you must pay the full cost of a Prescription Drug Product to the retail Network Pharmacy because you did not have your ID card, then you must submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. If, under this example, your payment to the retail Network Pharmacy for the covered Prescription Drug Product exceeds any applicable copay, then you will be reimbursed the difference, if any, between the applicable copay and the Prescription Drug Charge for the Prescription Drug Product.

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# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- 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 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. Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received. Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

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

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

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. 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 recognized as safe and effective for the treatment of cancer in any of the standard reference compendia: (A) The American Hospital Formulary Service's Drug Information, (B) One of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i). The Elsevier Gold Standard's Clinical Pharmacology; (ii) The National Comprehensive Cancer Network Drug and Biologics compendium; (iii) The Thomson Micromedix DrugDex, (C) two articles from major peer-reviewed medical journals that that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance. Cosmetic surgery and therapy does not include gender reassignment services.
- the following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics (unless services are an integral part of reconstructive surgery for Cleft Palate), periodontics, casts, splints and services for dental malocclusion, for any condition. However, facility charges and charges for general anesthesia or deep sedation which cannot be administered in a dental office are covered when Medically Necessary. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are also covered provided a continuous course of dental treatment is started within six months of an accident.
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision. This does not apply to obesity screening and counseling as outlined in the US Preventive Services Task Force.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training (other than behavioral training services for pervasive developmental disorder or autism), biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not

limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Care Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.

- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- corrective lenses and associated services (prescription exams and fittings), including eyeglass lenses and frames and contact lenses, except for the first pair of corrective lenses, or the first set of eyeglass lenses and frames and associated services for treatment of keratoconus or following 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 and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs. This does not apply to in-person and telephonic behavioral tobacco cessation counseling.
- for a diagnosis other than pervasive developmental disorder or autism, the following exclusions apply - genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition unless services are an integral part of reconstructive surgery for Cleft Palate.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- enteral feedings, supplies and specialty formulated medical foods that are prescribed and non-prescribed, except for infant formula needed for the treatment of inborn errors of metabolism.
- for services related to an Injury or Sickness paid under workers' compensation, occupational disease or similar laws.
- massage therapy.
- certain Medical Pharmaceuticals that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Medical Pharmaceutical(s) and is administered in connection with a covered service rendered in an inpatient, outpatient, Physician's office or home health care setting. Such determinations may be made periodically, and benefits for a Medical Pharmaceutical that was previously excluded under this provision may be reinstated at any time.

## General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.

- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.

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## Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

**Definitions**

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

**Plan**

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

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

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

**Closed Panel Plan**

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

**Primary Plan**

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

**Secondary Plan**

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

**Allowable Expense**

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.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

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

**Claim Determination Period**

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

**Reasonable Cash Value**

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

**Order of Benefit Determination Rules**

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

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

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

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

**Effect on the Benefits of This Plan**

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

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

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

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

**Recovery of Excess Benefits**

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

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If

we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

**Right to Receive and Release Information**

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

**Coordination of Benefits with Medicare**

If you, your spouse, or your Dependent is covered under this Plan and qualify for Medicare, federal law determines which plan is the primary payer and which is the secondary payer. The primary payer always determines covered benefits first, without considering what any other coverage will pay. The secondary payer determines its coverage only after the Primary Plan has completed its determination.

When Medicare is the Primary Payer

Medicare will be the primary payer and this Plan will be the secondary payer, even if you don't elect to enroll in Medicare or you receive services from a provider who does not accept Medicare payments, in the following situations:

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

When This Plan is the Primary Payer

This Plan will be the primary payer and Medicare will be the secondary payer in the following situations:

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

**Domestic Partners**

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

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

**Failure to Enroll in Medicare**

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

**Assistance with Medicare Questions**

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

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## Expenses For Which A Third Party May Be Responsible

This plan does not cover:

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

**Subrogation/Right of Reimbursement**

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

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

**Lien of the Plan**

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

**Additional Terms**

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof

including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

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

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# Payment of Benefits

**Assignment and Payment of Benefits**

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

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

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

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

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

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

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

**Recovery of Overpayment**

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

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# 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. However, your insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels your insurance.

## Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

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## Continuation of Coverage Under Cal-COBRA

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

**Employer groups with 20 or more Employees**

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

**Employer groups with less than 20 Employees**

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

**Notice Requirements**

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

**Qualifying Events for Continuation of Cal-COBRA Coverage**

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

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

**Notification Requirements**

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

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

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

If you or your Dependent do not notify Cigna (or an administrator acting on Cigna's behalf) in writing within 60

days of the Qualifying Event(s), you will be disqualified from receiving Cal-COBRA continuation coverage.

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

**Formal Election**

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

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

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

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

**Cal-COBRA Premium Payments**

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

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

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

- the date the Employer ceases to provide any group health plan to any Employee;
- the end of the period for which premium payments were made, if the qualified beneficiary ceases to make payments or fails to make timely payments of a required premium, in accordance with the terms and conditions of the policy;
- the first day after the date of election on which the qualified beneficiary first becomes covered under any other group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition for such person; or the date such exclusion or limitation no longer applies to the Employee or Dependent;
- the first day after the date of election on which the qualified beneficiary first becomes entitled to Medicare;
- the coverage for a qualified beneficiary that is determined to be disabled under the Social Security Act will terminate as described below;
- the qualified beneficiary moves out of the service area or the qualified beneficiary commits fraud or deception in the use of services.

**Continuation of Coverage for Totally Disabled Individuals**

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

disability shall notify Cigna (or an administrator acting on Cigna's behalf) within 30 days of a determination that the qualified beneficiary is no longer disabled.

**Continuation of Coverage Upon Termination of Prior Group Health Plan**

The Employer shall notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered as specified above, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled Employees are notified, whichever is later.

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

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

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

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

HC-TRM118 10-16

## Rescissions

Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

HC-TRM80 01-11

# Medical Benefits Extension

**Upon Policy Cancellation**

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury or Sickness, Medical Benefits will be paid without requirement of premium for Covered Expenses incurred in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:

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

**Totally Disabled**

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or

- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

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

HC-BEX7 04-10
V1

# Federal Requirements

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

HC-FED1 10-10

## Notice of Provider Directory/Networks

### Notice Regarding Provider 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

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the "Newborns' and Mothers' Health Protection Act": restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

HC-FED11 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 under ERISA

**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.

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

**Preservice Determinations**

When you or your representative requests a required prior authorization, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will

be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

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

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

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

**Concurrent Determinations**

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

**Postservice Determinations**

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

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

**Notice of Adverse Determination**

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any 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.

## 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

## ERISA Required Information

The name of the Plan is:

Millennium Health, LLC Welfare Benefit Plan

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

Millennium Health, LLC
16981 Via Tazon
San Diego, CA 92127
858-451-3535

| Employer Identification Number (EIN): | Plan Number: |
|---|---|
| 261565558 | 501 |

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The Plan's fiscal year ends on 12/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

**Plan Trustees**

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

**Plan Type**

The plan is a healthcare benefit plan.

**Collective Bargaining Agreements**

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

**Discretionary Authority**

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

**Plan Modification, Amendment and Termination**

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

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

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents

under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

**Statement of Rights**

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

**Continue Group Health Plan Coverage**

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

**Enforce Your Rights**

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HC-FED72 05-15

## Notice of an Appeal or a Grievance

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

HC-SPP4 04-10
V1

## 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.

If for any reason, you are not capable of appointing a new authorized representative, a duly authorized representative may do so on your behalf. If Cigna does not honor your designation of an authorized representative, you may request reconsideration of Cigna's determination by, as applicable, confirming that the signature on the authorization is yours, or that the authorized representative fully disclosed to you all relevant facts regarding its billing practices.

HC-AAR2 01-17

# When You Have A Complaint Or An Adverse Determination Appeal

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

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

**Start with Customer Service**

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

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

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

**Internal Appeal Procedure**

Cigna has a one-step appeal procedure for appeals decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

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

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

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

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

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection

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

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

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

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

**Independent Medical Review Procedures**

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

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

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

In order to qualify for an IMR, certain conditions must be met: your Physician has recommended a health care service as Medically Necessary and Cigna has disagreed with this determination, or you have received urgent care or emergency services that a Physician has deemed Medically Necessary and Cigna has disagreed with this determination, or you have been seen by a Physician for the diagnosis or treatment of the medical condition for which you are seeking an Independent Medical Review and Cigna has determined these services as not Medically Necessary or clinically appropriate.

Administrative, eligibility or benefit coverage limits or exclusions are not eligible for an independent medical appeal under this process. You remain entitled to send such issues to the CDI for a Department review.

**Independent Review Process for Experimental and Investigational Therapies**

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

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

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

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

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

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

Therapeutics and The United States Pharmacopoeia-Drug Information.

- any of the following reference compendia if recognized by the Federal Center for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology, The National Comprehensive Cancer Network Drug and Biologics Compendium, The Thomson Micromedex DrugDex.
- findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.
- peer-reviewed abstracts accepted for presentation at major medical association meetings.

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

**Assistance from the State of California**

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

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

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

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

**Notice of Benefit Determination on Appeal**

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the denial decision; reference to the specific policy provisions on which the decision is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

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

**Relevant Information**

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

### Legal Action

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

HC-APL415 01-20

## Definitions

### Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1186 HC-DFS1095V4 08-18

### Ambulance

Licensed ambulance transportation services involve the use of specially designed and equipped vehicles for transporting ill or injured patients. It includes ground, air, or sea transportation when Medically Necessary and clinically appropriate.

HC-DFS1406 01-20

### 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-DFS1130 HC-DFS840V2 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-DFS1130 HC-DFS841V2 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-DFS1130 HC-DFS842V3 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 – subject to the P&T Committee's findings – 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. The P&T Committee is responsible for ensuring that the plan offers a clinically appropriate

Prescription Drug List to enrollees consistent with the requirements of CIC 10123.201(b)(6).

A decision by the P&T Committee is paramount to a decision by the Business Decision Team.

HC-DFS1130 HC-DFS1099
10-16

**Charges**

The term charges means the actual billed charges; except when Cigna has contracted directly or indirectly for a different amount including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers of such services and/or supplies.

HC-DFS1193 01-19

**Chiropractic Care**

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

HC-DFS55 04-10
V1

**Custodial Services**

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

HC-DFS4 04-10
V1

**Dependent**

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. The plan may require written proof of such disability and dependency within 60 days of receiving our request for written proof. After the original proof is received, the plan may ask for proof of handicap/dependency annually, after the two year period following the child's 26th birthday.

The term child means a child born to you, a child legally adopted by you from the date the child is placed in your physical custody prior to the finalization of the child's adoption, or a child supported by you pursuant to a court order (including a qualified medical child support order). It also includes a stepchild or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

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

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

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

HC-DFS1023 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-DFS1131 HC-DFS845V2
10-16

**Domestic Partner**

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

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

HC-DFS1024 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; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to stabilize the patient.

HC-DFS1414 01-20

**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 30 hours a week for the Employer.

HC-DFS1186 HC-DFS1189
08-18

**Employer**

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

**Essential Health Benefits**

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

HC-DFS411 01-11

**Expense Incurred**

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

HC-DFS10 04-10
V1

**Free-Standing Surgical Facility**

The term Free-Standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;

- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

A Free-Standing Surgical Facility, unless specifically noted otherwise, is covered with the same cost share as an Outpatient Facility.

HC-DFS1407 01-20

**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-DFS1131 HC-DFS846V3 10-16

**Hospice Care Program**

The term Hospice Care Program means:

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

HC-DFS51 04-10 V1

**Hospice Care Services**

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

HC-DFS52 04-10 V1

**Hospice Facility**

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

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

HC-DFS53 04-10 V1

**Hospital**

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance 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 does not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

HC-DFS1415 01-20 V2

**Hospital Confinement or Confined in a Hospital**

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

HC-DFS49 04-10
V1

**Injury**

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

**Maintenance Treatment**

The term Maintenance Treatment means:

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

HC-DFS56 04-10
V1

**Maximum Reimbursable Charge - Medical**

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- a policyholder-selected percentage of a schedule that Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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

In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. 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.

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

HC-DFS1196 01-19

**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 Professional 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-DFS1410 01-20

**Medically Necessary/Medical Necessity**

Health care 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 Professional;
- 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.

In determining whether health care services, supplies, or medications are Medically Necessary, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

HC-DFS1411 01-20

**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 Room and Board, made by a Hospital for medical services and supplies actually used during Hospital Confinement.

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

HC-DFS1409 01-20

**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.

This term may also include, as applicable, an entity that has directly or indirectly contracted with Cigna to arrange for the provision of any Prescription Drug Products the charges for which are Covered Expenses.

HC-DFS1305 HC-DFS1198V1
01-19

**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-DFS1305 HC-DFS850V2
01-19

**Nurse**

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

HC-DFS22 04-10
V1

**Other Health Care Facility**

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-DFS1412 01-20

**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 nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS1413 01-20

**Participating Provider**

The term Participating Provider means a person or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies, the Charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the Charges for which are Covered Expenses.

HC-DFS1194 01-19

**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-DFS1178 HC-DFS851V2

**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, and the composition of which satisfies the membership requirements of CIC 10123.201. 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.

A decision by the P&T Committee is paramount to a decision by the Business Decision Team.

HC-DFS1178 HC-DFS1100

**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 Prescription Drug Charge is the amount that, prior to application of the plan's cost-share requirement(s), is payable by Cigna to its Pharmacy Benefit Manager for a specific covered Prescription Drug Product dispensed at a Network Pharmacy, including any applicable dispensing fee and tax. The "Pharmacy Benefit Manager" is the business unit, affiliate, or other entity that manages the Prescription Drug Benefit for Cigna.

HC-DFS1178 HC-DFS1179

**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-DFS1178 HC-DFS854V2

**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-DFS1178 HC-DFS855V2

**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-DFS1178 HC-DFS856V2

**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-DFS1178 HC-DFS857V2

**Preventive Treatment**

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

HC-DFS57 04-10
V1

**Primary Care Physician**

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

HC-DFS167 04-10
V2

**Psychologist**

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

HC-DFS26 04-10
V1

**Review Organization**

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

HC-DFS30 04-10
V1

**Room and Board**

The term Room and Board includes all charges made by a Hospital for room and meals and for all general services and activities needed for the care of registered bed patients.

HC-DFS1408 01-20

**Serious Emotional Disturbances**

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

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

HC-DFS168 04-10
V2

**Severe Mental Illness**

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

HC-DFS169 04-10
V1

**Sickness – For Medical Insurance**

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

HC-DFS50 04-10
V1

**Skilled Nursing Facility**

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

HC-DFS31 04-10
V1

**Specialist**

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

HC-DFS33 04-10
V1

**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.

HC-DFS1135 HC-DFS858V2
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-DFS1135 HC-DFS859V2
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-DFS1135 HC-DFS860V2
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-DFS1135 HC-DFS861V2
10-16