Pace University

OPEN ACCESS PLUS MEDICAL
BENEFITS
(90/70 Plan)

EFFECTIVE DATE: July 1, 2015

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

Printed in U.S.A.
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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: Pace University

GROUP POLICY(S) — COVERAGE
3331784 – CN6 OPEN ACCESS PLUS MEDICAL BENEFITS

EFFECTIVE DATE: July 1, 2015

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

Anna Krishtul, Corporate Secretary
Explanation of Terms
You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule
The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.
Special Plan Provisions

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

Services Available in Conjunction With Your Medical Plan

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

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.

The Review Organization assesses each case to determine whether Case Management is appropriate.

You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.

The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).

The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).

Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

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.

CIGNA HEALTHY REWARDS® PROGRAM

Part of Cigna's commitment to give you access to quality care and related programs is Cigna HealthCare’s Healthy Rewards program. This program includes special discounts, on certain programs and services that are designed to help you enhance your health and wellness.

As an insured person under this certificate, you have the choice to use Healthy Rewards. The program is separate from your coverage under this certificate, so any services you receive are not subject to copayments, deductibles, coinsurance or doctor referral requirements that may apply to your Medical Benefits. If this certificate provides coverage for any of the services described below, this Healthy Rewards program is in addition to, and not instead of, your plan benefits.

If you decide to utilize any of the programs described below, you will set the appointments yourself, and show your I.D. card when you pay for the service.

 Discounts are available for these health and wellness programs:

**Fitness**
- Fitness Club and Equipment Discounts through GlobalFit
- Fitness Club and Equipment Discounts (American Specialty Health (“ASH”))
- Just Walk 10,000 Steps-a-Day™
- Curves®

**Weight Management and Nutrition**
- Healthyroads for Living
- Healthyroads Weight Management Program (ASH)
- Registered Dietitian Network
- Jenny Craig®
- Weight Watchers®
- NutriSystem®

**Vision and Hearing Care**
- Exams, Eyewear and Contacts
- Vision Exams & Eye Ware
- Lasik Vision Correction
- Hearing Exams and Aids
- Hearing Exams and Aids (hearPO)

**Tobacco Cessation**
- Healthyroads for Living Tobacco Cessation Program
- Healthyroads Tobacco Cessation Program (ASH)
- Tobacco Solutions™
- Quitnet®

**Alternative Medicine/Alternative Medicine (ASH)**
- Acupuncture
- Chiropractic
- Massage Therapy

**Mind/Body**
- Healthyroads for Living Mind/Body Program
- Healthyroads Mind/Body Program (ASH)
- Yoga Journal (subscriptions, DVDs, yoga conference discounts)
- SpaFinder™

**Dental Care**
- Anti-cavity Products through Epic™
- Sonicare®

**Vitamins, Health & Wellness Products**
- Drugstore.com™
- ChooseHealthy™ (ASH)
- Healthyroads for Living (discounts on natural supplements)
- Registered Dietitian Network (ASH)

**Healthy Lifestyle Products**
- Coupons for food and over-the-counter health and wellness products through Linkwell
- Mayo Clinic Books
- Magazine Subscriptions

Not all Healthy Rewards programs are available in all states. For complete information on Healthy Rewards, please visit myCigna.com and go to the My Health page, or call 1.800.870.3470.

HC-SPP3  04-10
HC-IMP21

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-NOT3 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

Outpatient Substance Abuse Rehabilitation Services

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

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

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

Substance Abuse Detoxification Services

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

Mental Health and Substance Abuse Exclusions:

The following exclusion is hereby deleted and no longer applies:

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

Terms within the agreement:

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

Visit Limits:

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

Prior Authorization

Below is a list of drugs that may require Prior Authorization when they are covered by your plan.

Please see our website at www.Cigna.com for the most current listing of drugs that require Prior Authorization, or call the Member Services number on the back of your I.D. card.

Agents to Treat Multiple Sclerosis

Avonex
Betaseron
Copaxone
Rebif

Antineoplastic LHRH (GNRH) Agonist, Pituitary Suppr.
Lupron
Zoladex

Aminoglycosides
Garamycin
Nebcin
Tobramycin Sulfate

Antineoplastic Systemic Enzyme Inhibitors
Gleevec
Iressa
Nexavar
Tarceva

Analgesics, Narcotics
Actiq

Antiparkinsonism Drugs, Other
Apokyn

Androgenic Agents
Delataseyl
Depo-Testosterone
Testosterone Propionate

Antipsoriatics Agents, Systemic
Raptiva

Anti-Inflammatory, Tumor Necrosis Factor Inhibitor
Enbrel

Antivirals, HIV- Specific, Fusion Inhibitor
Fuzeon

Anti-Inflammatory, Interleukin - 1 Receptor Antagonist
Kineret

Bone Formation Stim. Agent
Forteo
Miacalcin

Anti-Inflammatory, Pyrimid Synthesis Inhibitor
Arava

Cephalosporins - 3rd Generation
Rocephin

Anti-Inflammatory, Tumor Necrosis Factor Inhibitor
Humira

Drugs to Treat Impotency
Caverject
Cialis
Edex
Levitra
Muse
Viagra
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<td>Lotensin</td>
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<td>Olux-Olux-E</td>
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<td>Pediaderm HC</td>
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<tr>
<td>Heartburn/Ulcer</td>
<td>Nerve Pain</td>
<td>Antidepressants</td>
<td>Atypical Antipsychotics</td>
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<tr>
<td>Aciphex</td>
<td>Lyrica</td>
<td>Aplenzin</td>
<td>Abilify</td>
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<td>Celexa</td>
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<td>Geodon</td>
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<td>Prozac Weekly</td>
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<td>Rapidflux</td>
<td>Risperdal</td>
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<td>Sarafem</td>
<td>Risperdal M</td>
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<td>Selfemra</td>
<td>Saphris</td>
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<td>Wellbutrin SR</td>
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<td>Zoloft</td>
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</tbody>
</table>

**Sleep Disorder**

- Ambien
- Edluar
- Lunesta
- Rozerem
- Sonata

**Anti-Allergy Inhaled Nasal Steroids**

- Beconase AQ
- Flonase
- Nasacort AQ
- Nasarel
- Omnaris
- Rhinocort Aqua
- Veramyst

**Asthma Nebulizer Solutions**

- Accuneb
- Brovana
- Perforomist
- Xopenex

**Antidepressants**

- Aplenzin
- Celexa
- Effexor
- Paxil
- Pexeva
- Prozac
- Prozac Weekly
- Rapidflux
- Sarafem
- Selfemra
- Wellbutrin
- Wellbutrin SR
- Zoloft

**Atypical Antipsychotics**

- Abilify
- Abilify Discmelt
- Clozaril
- Fanapt
- Fazaclo
- Geodon
- Invega
- Risperdal
- Risperdal M
- Saphris
### Non-Narcotic Pain Relievers
- Anaprox
- Ansaid
- Arthrotec
- Cambia
- Cataflam
- Clinoril
- Daypro
- EC-Naprosyn
- Flector Patch
- Indocin SR
- Lodine
- Lodine XL
- Mobic
- Motrin
- Nalfon
- Naprelan
- Naprosyn
- Pennsaid
- Prevacid Naprapac
- Sulindac
- Tolectin DS
- Vimovo
- Voltaren
- Voltaren Gel
- Zipsor

### Oral Narcotic Pain Relievers
- Alcet
- Balacet
- Bancap HC
- Darvocet-N 50
- Darvon
- Darvon-N
- Dazodpx
- Demerol
- Dilaudid
- Hycet
- Liquicet
- Lorcat
- Lorcat Plus
- Lortab
- Lortab ASA
- Magnacet
- Maxidone
- Norco
- Nucynta
- Oxy-IR
- Panlor DC
- Panlor SS
- Percocet
- Percodan
- Primalev
- Roxicodone
- Ryzolt
- Soma Compound/Codeine
- Synalgos-DC
- Talwin Compound
- Talwin NX
- Tylox
- Ultracet
- Ultram
- Ultram ER
- Vicodin
- Vicodin ES
- Vicodin HP
- Vicoprofen
- Xodol
- Zamice
- Zydone

### Authorization
No authorization will be required prior to receiving Emergency Services.

### Non-English Assistance
For non-English assistance in speaking to Member Services, please use the translation service provided by AT&T. For a translated document, please contact Customer Service at the toll-free telephone number shown on your ID card.

### Utilization Review Procedures

#### Health Care Services
The following applies only to the In-Network plan.

After receipt of necessary information, utilization review shall be performed and a determination shall be provided by telephone and in writing to you and your provider; for healthcare services which require preauthorization, in three working days; and to the provider for continued or extended treatment prescribed by a provider, in one working day.

A determination will be made for health care services received within 30 days of receipt of necessary information.

If an adverse determination has been rendered in the absence of a discussion with the provider, the provider may request reconsideration of the adverse determination.

Except in the case of a retrospective review, the reconsideration shall occur within one working day after receipt of the request and shall be conducted by your provider and clinical peer reviewer making the initial determination, or his designee. If the adverse determination is upheld after reconsideration, the reviewer shall provide notice as stated above. This does not waive your right to an appeal.

Please contact Customer Service by calling the toll-free telephone number shown on your ID card.

#### Home Health Services Following a Hospital Admission
After receiving a request for coverage of Home Health Services following an inpatient Hospital admission, we will notify you or your designee of our decision by telephone and writing, within one business day of receipt of all necessary information, or, when the day subsequent to the request falls on a weekend or holiday, within 72 hours of receipt of all necessary information.

When we receive a request for Home Health Services and all necessary information prior to your discharge from an inpatient Hospital admission, we will not deny coverage for Home Health Services, either on the basis of Medical Necessity or for failure to obtain Prior Authorization, while our decision is pending.

Appeals of an adverse determination of Home Health Services following an inpatient Hospital admission will be handled on an expedited basis. For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to your case.

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**Health Care Services**
A denial of claim or a clinical decision regarding health care services will be made by qualified clinical personnel. Notice of denial or determination will include information regarding the basis for denial or determination and any further appeal rights.
to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours of receipt of the appeal request or two business days of receipt of necessary information. Our failure to render a determination of your internal appeal within this timeframe shall be deemed a reversal of the initial adverse determination. If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal.

How To File Your Claim

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

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

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA’S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.
  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 120 days 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 120 days, the claim will not be invalidated nor reduced if it is shown that it was submitted as soon as was reasonably possible.

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, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000.00 and the stated value of the claim for each such violation.

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 28 hours a week; or
- you are a full time faculty who have been provided with contractual arrangement whereby work part time, but not less than half of your standard workload, you will be considered full time for the duration of the year; 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 & coincident with the first.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.
Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

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

Effective Date of Dependent Insurance

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

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns

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

If a premium contribution is required for you to add such child to your Dependent Insurance, you must elect to insure the child within 31 days after the birth, in order to continue the child’s coverage after the end of the 31-day period. If your Dependent Insurance for the child ends at the end of the 31 day period, no benefits for expenses incurred after 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, if you choose.
Open Access Plus Medical Benefits

The Schedule

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

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

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

Copayments/Deductibles
Copayments are expenses to be paid by you or your Dependent for covered services. Note: if the costs of a covered service is less than the copayment for that service, you or your Dependent are responsible for the lesser amount. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

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

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

- Coinsurance.
- Plan Deductible.
- Any copayments and/or benefit deductibles.

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.

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

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.
Open Access Plus Medical Benefits

The Schedule

**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.

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
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</thead>
<tbody>
<tr>
<td>Lifetime Maximum for non-Essential and Essential Health Benefits * *(Essential Health benefits are noted throughout the Schedule as EHB)</td>
<td></td>
<td>Unlimited</td>
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</table>
### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>The Percentage of Covered Expenses the Plan Pays</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
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</thead>
<tbody>
<tr>
<td><strong>Note:</strong></td>
<td>90%</td>
<td>70% of the Maximum Reimbursable Charge</td>
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<tr>
<td>&quot;No charge&quot; means an insured person is not required to pay Coinsurance.</td>
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</table>

### Maximum Reimbursable Charge

Maximum Reimbursable Charge is determined based on the lesser of the provider’s normal charge for a similar service or supply; or

- A percentage of a schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:
  - the provider’s normal charge for a similar service or supply; or
  - the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company.

**Note:**
The provider may bill you for the difference between the provider’s normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.

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<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
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</thead>
<tbody>
<tr>
<td>Maximum Reimbursable Charge</td>
<td>Not Applicable</td>
<td>300%</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
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<tr>
<td>Calendar Year Deductible</td>
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<tr>
<td>Individual</td>
<td>$250 per person</td>
<td>$1,200 per person</td>
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<tr>
<td>Family Maximum</td>
<td>$500 per family</td>
<td>$2,400 per family</td>
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<tr>
<td>Family Maximum Calculation</td>
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<tr>
<td><strong>Individual Calculation:</strong></td>
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<tr>
<td>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.</td>
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</table>

<p>| Out-of-Pocket Maximum |            |                |
| Individual            | $1,200 per person | $2,500 per person |
| Family Maximum        | $2,400 per family  | $5,000 per family  |
| Family Maximum Calculation |        |                |
| <strong>Individual Calculation:</strong> |            |                |
| Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%. | | |</p>
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<tr>
<th><strong>BENEFIT HIGHLIGHTS</strong></th>
<th><strong>IN-NETWORK</strong></th>
<th><strong>OUT-OF-NETWORK</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Physician’s Services</strong></td>
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<tr>
<td><strong>EHB</strong></td>
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</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>No charge after $25 per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visits</td>
<td>No charge after $25 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Consultant and Referral Physician’s Services</td>
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<tr>
<td><strong>Note:</strong> OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.</td>
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</tr>
<tr>
<td>Surgery Performed in the Physician’s Office</td>
<td>No charge after the $25 PCP or $25 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Second Opinion Consultations (provided on a voluntary basis)</td>
<td>No charge after the $25 PCP or $25 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Allergy Treatment/Injections</td>
<td>No charge after either the $25 PCP or $25 Specialist per office visit copay or the actual charge, whichever is less</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Allergy Serum (dispensed by the Physician in the office)</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
</tbody>
</table>

| **Preventive Care** |                |                   |
| **EHB**            |                |                   |
| Routine Preventive Care - all ages | No charge | 70% after plan deductible |
| Immunizations - all ages | No charge | 70% after plan deductible |

| **Mammograms, PSA, PAP Smear** |                |                   |
| **EHB**                       |                |                   |
| Preventive Care Related Services (i.e. “routine” services) | No charge | 70% after plan deductible |
| Diagnostic Related Services (i.e. “non-routine” services) | Subject to the plan’s x-ray & lab benefit; based on place of service | Subject to the plan’s x-ray & lab benefit; based on place of service |

<p>| <strong>Inpatient Hospital - Facility Services</strong> |                |                   |
| <strong>EHB</strong>                                  |                |                   |
| Semi-Private Room and Board              | Limited to the semi-private room negotiated rate | Limited to the semi-private room rate |
| Private Room                             | Limited to the semi-private room negotiated rate | Limited to the semi-private room rate |
| Special Care Units (ICU/CCU)             | Limited to the negotiated rate | Limited to the ICU/CCU daily room rate |</p>
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
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</thead>
<tbody>
<tr>
<td><strong>Outpatient Facility Services</strong></td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Physician’s Visits/Consultations</strong></td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Professional Services</strong></td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon, Radiologist, Pathologist, Anesthesiologist</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td><strong>Outpatient Professional Services</strong></td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon, Radiologist, Pathologist, Anesthesiologist</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Emergency and Urgent Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $25 PCP or $25 Specialist per office visit copay</td>
<td>No charge after the $25 PCP or $25 Specialist per office visit copay</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>No charge after $80 per visit copay*</td>
<td>No charge after $80 per visit copay*</td>
</tr>
<tr>
<td></td>
<td>*waived if admitted</td>
<td>*waived if admitted</td>
</tr>
<tr>
<td></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient Professional Services (radiology, pathology and ER Physician)</td>
<td>No charge after $25 per visit copay*</td>
<td>No charge after $25 per visit copay*</td>
</tr>
<tr>
<td></td>
<td>*waived if admitted</td>
<td>*waived if admitted</td>
</tr>
<tr>
<td></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Urgent Care Facility or Outpatient Facility</td>
<td>No charge after $25 per visit copay*</td>
<td>No charge after $25 per visit copay*</td>
</tr>
<tr>
<td></td>
<td>*waived if admitted</td>
<td>*waived if admitted</td>
</tr>
<tr>
<td></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td>Independent x-ray and/or Lab Facility in conjunction with an ER visit</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Ambulance</td>
<td>90% after plan deductible</td>
<td>90% after plan deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services at Other Health Care Facilities</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum: 60 days combined</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory and Radiology Services (includes pre-admission testing)</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Hospital Facility</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Independent X-ray and/or Lab Facility</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
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</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Short-Term Rehabilitative Therapy</td>
<td>No charge after the $25 PCP or $25 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum: 90 days for all therapies combined</td>
<td></td>
<td></td>
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<tr>
<td>Note: The Short-Term Rehabilitative Therapy maximum does not apply to the treatment of autism.</td>
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<tr>
<td>Includes:</td>
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<tr>
<td>Cardiac Rehab</td>
<td></td>
<td></td>
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<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
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<tr>
<td>Speech Therapy</td>
<td></td>
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<tr>
<td>Occupational Therapy</td>
<td></td>
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<tr>
<td>Pulmonary Rehab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Therapy</td>
<td></td>
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</tr>
<tr>
<td>Chiropractic Care</td>
<td>No charge after the $25 PCP or $25 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>90% after the home Health care deductible</td>
<td>75% after the home Health care deductible.</td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regardless of the Individual Plan Deductible, the Home Health Care Deductible will not exceed $50.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>90% after plan deductible</td>
<td></td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>90% after plan deductible</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bereavement Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*EHB Services provided as part of Hospice Care</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Inpatient</td>
<td>90% after plan deductible</td>
<td>Covered under Mental Health Benefit</td>
</tr>
<tr>
<td>Outpatient</td>
<td>70% after plan deductible</td>
<td>Covered under Mental Health Benefit</td>
</tr>
<tr>
<td>Bereavement Counseling Services provided by Mental Health Professional</td>
<td>Covered under Mental Health Benefit</td>
<td>Covered under Mental Health Benefit</td>
</tr>
<tr>
<td>Maternity Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*EHB Initial Visit to Confirm Pregnancy</td>
<td>No charge after the $25 PCP or $25 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Note: OB/GYN providers will be considered either as a PCP or Specialist depending on how the provider contracts with the Insurance Company.</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>All subsequent Prenatal Visits, Prenatal Visits and Physician’s Delivery Charges (i.e. global maternity fee)</td>
<td>No charge after the $25 PCP or $25 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Delivery - Facility (Inpatient Hospital, Birthing Center)</td>
<td>70% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Abortion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*EHB Includes elective and non-elective procedures</td>
<td>No charge after the $25 PCP or $25 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
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<tr>
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</tr>
<tr>
<td><strong>Women’s Family Planning Services</strong>&lt;br&gt;<em>EHB</em>&lt;br&gt; Office Visits, Lab and Radiology Tests and Counseling&lt;br&gt; Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)&lt;br&gt; • Physician’s Office Visit&lt;br&gt; • Inpatient Facility&lt;br&gt; • Outpatient Facility&lt;br&gt; • Physician’s Services</td>
<td>No charge</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td><strong>Men’s Family Planning Services</strong>&lt;br&gt;<em>EHB</em>&lt;br&gt; Office Visits, Lab and Radiology Tests and Counseling&lt;br&gt; Surgical Sterilization Procedures for Vasectomy (excludes reversals)&lt;br&gt; • Physician’s Office Visit&lt;br&gt; • Inpatient Facility&lt;br&gt; • Outpatient Facility&lt;br&gt; • Physician’s Services</td>
<td>No charge after the $25 PCP or $25 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td><strong>Infertility Treatment</strong>&lt;br&gt;<em>EHB (except for In-vitro, GIFT and ZIFT)</em>&lt;br&gt;Coverage will be provided for the following services:&lt;br&gt; • Testing and treatment services performed in connection with an underlying medical condition.&lt;br&gt; • Testing performed specifically to determine the cause of infertility.&lt;br&gt; • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).&lt;br&gt; • Artificial Insemination, In-vitro, GIFT, ZIFT, etc.&lt;br&gt; • Physician’s Office Visit (Lab and Radiology Tests, Counseling)&lt;br&gt; • Inpatient Facility&lt;br&gt; • Outpatient Facility&lt;br&gt; • Physician’s Services</td>
<td>No charge after the $25 PCP or $25 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
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<td>--------------------------------------------------------</td>
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<tr>
<td><strong>Organ Transplants</strong></td>
<td></td>
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</tr>
<tr>
<td><em>EHB (Applicable to In-Network Benefits only. Does not include travel).</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes all medically appropriate, non-experimental transplants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $25 PCP or $25 Specialist per office visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100% at Lifesource center, otherwise 90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100% after at Lifesource center, otherwise 90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Lifetime Travel Maximum: $10,000 per transplant</td>
<td>No charge (only available when using Lifesource facility)</td>
<td>In-Network coverage only</td>
</tr>
</tbody>
</table>

| **Durable Medical Equipment**                           |                                               |                                                |
| *EHB                                                   |                                               |                                                |
| Calendar Year Maximum: Unlimited                       | 90% after plan deductible                     | 70% after plan deductible                      |

| **External Prosthetic Appliances**                      |                                               |                                                |
| *EHB                                                   |                                               |                                                |
| Calendar Year Maximum: Unlimited                       | 90% after plan deductible                     | 70% after plan deductible                      |

| **Diabetic Equipment**                                  |                                               |                                                |
| *EHB                                                   |                                               |                                                |
| Calendar Year Maximum: Unlimited                       | 90% after plan deductible                     | 70% after plan deductible                      |

| **Wigs**                                                |                                               |                                                |
| *EHB                                                   |                                               |                                                |
| Calendar Year Maximum: Unlimited                       | 90% after plan deductible                     | 70% after plan deductible                      |

<p>| <strong>Nutritional Evaluation</strong>                              |                                               |                                                |
| <em>EHB (applicable to treatment of diabetes; treatment of eating disorders; and in connection with enteral formulas as a result of an underlying medical condition)</em> |                                               |                                                |
| Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of diabetes or treatment prescribed in connection with mental health diagnosis. |                                               |                                                |
| Physician’s Office Visit                                | No charge after the $25 PCP or $25 Specialist per office visit copay | 70% after plan deductible                      |
| Inpatient Facility                                      | 90% after plan deductible                     | 70% after plan deductible                      |
| Outpatient Facility                                     | 90% after plan deductible                     | 70% after plan deductible                      |
| Physician’s Services                                    | 90% after plan deductible                     | 70% after plan deductible                      |</p>
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>EHB (for oral surgery only)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to charges made for a continuous course of</td>
<td></td>
<td></td>
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<tr>
<td>dental treatment started within twelve months of an</td>
<td></td>
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<tr>
<td>injury to sound, natural teeth and charges made for</td>
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<tr>
<td>dental care and treatment due to congenital disease or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>anomaly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $25 PCP or $25 Specialist</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>per office visit copay</td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td><strong>TMJ Surgical and Non-Surgical</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always excludes appliances and orthodontic treatment.</td>
<td>No charge after the $25 PCP or $25 Specialist</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Subject to medical necessity.</td>
<td>per office visit copay</td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td><strong>Routine Foot Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*EHB (when provided in connection with treatment of</td>
<td>Not covered except for services associated</td>
<td>Not covered except for services associated</td>
</tr>
<tr>
<td>diabetes)</td>
<td>with foot care for diabetes and peripheral</td>
<td>with foot care for diabetes and peripheral</td>
</tr>
<tr>
<td></td>
<td>vascular disease when Medically Necessary.</td>
<td>vascular disease when Medically Necessary.</td>
</tr>
<tr>
<td><strong>Treatment Resulting From Life Threatening Emergencies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical treatment required as a result of an emergency,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>such as a suicide attempt, will be considered a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>medical expense until the medical condition is</td>
<td></td>
<td></td>
</tr>
<tr>
<td>stabilized. Once the medical condition is stabilized,</td>
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<td></td>
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<tr>
<td>whether the treatment will be characterized as either</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a medical expense or a mental health/substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>expense will be determined by the utilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>review Physician in accordance with the applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mixed services claim guidelines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient (Includes Individual, Group and Intensive</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>$25 per visit copay</td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
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<td>-----------------------------------------</td>
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<td>-------------------------------------</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*EHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient (Includes Individual and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Outpatient)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>$25 per visit copay</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No Charge</td>
<td>70% after plan deductible</td>
</tr>
</tbody>
</table>
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Utilization Review

Cigna reviews health services to determine whether the services are or were Medically Necessary or experimental or investigational (“Medically Necessary”). This process is called Utilization Review (UR). Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the Utilization Review process, please call the number on your ID card.

All determinations that services are not Medically Necessary will be made by licensed Physicians or by licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the health care Provider who typically manages your medical condition or disease or provides the health care service under review. Cigna does not compensate or provide financial incentives to our employees or reviewers for determining that services are not or were not Medically Necessary. Cigna has developed guidelines and protocols to assist in this process. Specific guidelines and protocols are available for your review upon request. For more information, you can contact us.

Preauthorization Reviews

If we have all the information necessary to make a determination regarding a Preauthorization review, we will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within three business days of receipt of the request.

If we need additional information, we will request it within three business days. You or your Provider will then have 45 calendar days to provide the requested information. If we receive the requested information within 45 days, we will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within three business days of our receipt of the information. If all necessary information is not received within 45 days, we will make a determination within 15 calendar days of the end of the 45 day period.

Urgent Preauthorization Reviews. With respect to urgent Preauthorization requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your Provider, by telephone, within 72 hours of receipt of the request. Written notice will follow within one calendar day of the decision. If we need additional information, we will request it within 24 hours. You or your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your Provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

After receiving a request for coverage of home care services following an inpatient Hospital admission, we will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within one business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, we will make a determination and provide notice to you (or your designee) and your Provider within 72 hours of receipt of the necessary information. When we receive a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home care services while our decision on the request is pending.

Concurrent Reviews

Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your Provider, by telephone and in writing, within one business day of receipt of all necessary information. If we need additional information, we will request it within one business day. You or your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within one business of our receipt of the information or, if we do not receive the information, within one business day of the end of the 45-day time period.

Urgent Concurrent Reviews. For concurrent reviews that involve an extension of Urgent Care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, we will make a determination and provide notice to you and your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one business day of receipt of the request for coverage if all necessary information was included or three calendar days from the verbal notification if all necessary information was not included. If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, the Urgent Preauthorization Review timeframes apply.

Retrospective Reviews

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and notify you and your Provider within 30 calendar days of the receipt of the request. If we need additional information, we will request it within 30 calendar days. You or your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to you and your Provider in writing within 15 calendar days of
the earlier of our receipt of the information or the end of the 45 day period.

Once we have all the information to make a decision, our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

**Retrospective Review of Preauthorized Services**

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had we been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

**Reconsideration**

If we did not attempt to consult with your Provider before making an adverse determination, your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Preauthorization and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and your Provider, by telephone and in writing.

**Utilization Review Internal Appeals**

You, your designee, and, in retrospective review cases, your Provider, may request an internal Appeal of an adverse determination, either by phone or in writing.

You also have the right to Appeal the denial of a Preauthorization request for an Out-of-Network health service when we determine that the Out-of-Network health service is not materially different from an available In-Network health service. A denial of an Out-of-Network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. You are not eligible for a Utilization Review Appeal if the service you request is available from a Participating Provider, even if the Non-Participating Provider has more experience in diagnosing or treating your condition. (Such an Appeal will be treated as a Grievance.) For a Utilization Review Appeal of denial of an Out-of-Network health service, you, or your designee, must submit:

- A statement from your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat your condition, that the requested Out-of-Network health service is materially different from the alternate health service available from a Participating Provider that we approved to treat your condition; and
- Two documents from the available medical and scientific evidence that the Out-of-Network service:
  - Is likely to be more clinically beneficial to you than the alternate In-Network service; and
  - That the adverse risk of the Out-of-Network service would likely not be substantially increased over the In-Network health service.

You have up to 180 calendar days after you receive notice of the adverse determination to file an Appeal. We will acknowledge your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will be necessary, inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

**First Level Appeal**

If your Appeal relates to a Preauthorization request, we will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee) and where appropriate your Provider within two business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

If your Appeal relates to a retrospective claim, we will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee) and where appropriate your Provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

** Expedited Appeals.** Appeals of reviews of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. Expedited Appeals are not available for retrospective reviews. For Expedited Appeals, your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal.
with one business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited Appeals will be determined within the lesser of 72 hours from receipt of the Appeal or two business days of receipt of the information necessary to conduct the Appeal.

If you are not satisfied with the resolution of your Expedited Appeal, you may file a standard internal Appeal or an external appeal.

Our failure to render a determination of your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two business days of receipt of the necessary information for an Expedited Appeal will be deemed a reversal of the initial adverse determination.

Second Level Appeal

If you disagree with the first level Appeal determination, you (or your designee) can file a second level Appeal. You (or your designee) can also file an external appeal. The four month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for you to file an external appeal.

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level Appeal. We will acknowledge your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will, if necessary, inform you of any additional information needed before a decision can be made.

If your Appeal relates to a Preauthorization request, we will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee) and where appropriate your Provider within two business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

If your Appeal relates to a retrospective claim, we will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee) and where appropriate your Provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

If you need assistance filing an Appeal you may contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

- as a registered bed patient, except for 48/96 hour maternity stays;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for Mental Health or Substance Abuse Residential Treatment Services.

PAC and CSR are terms we use to describe your responsibilities to notify us when you receive care from an Out-of-Network provider in connection with the Preauthorization and Concurrent Review process described earlier in this provision.

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 72 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 the lesser of 50% or $500 of Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 72 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will be reduced by the lesser of 50% or $500:

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

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

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the “Coordination of Benefits” section.
Outpatient Certification Requirements - Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-standing Surgical Facility, Other Health Care Facility or a Physician’s office. You or your Dependent should call the toll-free number on the back of your ID card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should only be requested for 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 the lesser of 50% or $500 for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will be reduced by the lesser of 50% or $500 for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but which was not certified as Medically Necessary.

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

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:
- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Hysterectomy.
- inpatient services at any participating Other Health Care Facility;
- outpatient facility services;
- intensive outpatient programs;
- advanced radiological imaging;
- non-emergency ambulance; or
- transplant services.

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. Any applicable Copayments, Deductibles or limits are shown in The Schedule.

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided, including Pre-Hospital Emergency Medical Services for the treatment of an Emergency Medical Condition when such services are provided by an ambulance service. Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed is also covered.

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:
- inpatient Hospital services, except for 48/96 hour maternity stays;
“Pre-Hospital Emergency Medical Services” means the prompt evaluation and treatment of an Emergency Medical Condition and/or transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the N.Y. Public Health Law. However, services are only covered when transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- serious impairment to such person’s bodily functions;
- serious dysfunction of any bodily organ or part of such person; or
- serious disfigurement of such person.

An ambulance service may not charge or seek reimbursement from a covered person for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable Copayment, Coinsurance, or Deductible.

Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Medical Condition do not require preauthorization.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities is covered when the transportation is any of the following:

- from a non-Participating Hospital to a Participating Hospital.
- to a Hospital that provides a higher level of care that was not available at the original Hospital.
- to a more cost-effective acute care facility.
- from an acute Facility to a sub-acute setting.

See The Schedule section of this Certificate for any preauthorization requirements for non-emergency transportation.

Benefits do not include travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by Cigna, even though prescribed by a Physician. Non-ambulance transportation such as ambulette, van or taxi cab is not covered.

Coverage for air ambulance related to an Emergency Medical Condition or air ambulance related to non-emergency transportation is provided when a covered person’s medical condition is such that transportation by land ambulance is not appropriate; and that medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one of the following is met:

- the point of pick-up is inaccessible by land vehicle; or
- great distances or other obstacles (for example, heavy traffic) prevent timely transfer to the nearest Hospital with appropriate facilities.

- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services for the treatment of an Emergency Medical Condition and for Urgent Care. Coverage for Emergency Services for treatment of an Emergency Medical Condition is provided regardless of whether the provider is a Participating Provider. Coverage for Emergency Services for treatment of an Emergency Medical Condition is provided worldwide. However, only Emergency Services and supplies that are medically Necessary and are performed to treat to stabilize and Emergency Medical Condition are covered.

- Hospital Emergency Department Visits. In the event that a covered person requires treatment for an Emergency Medical Condition, that person should seek immediate care at the nearest Hospital emergency department or call 911. Emergency department care does not require preauthorization. However, only Emergency Services for the treatment of an Emergency Medical Condition, as defined, are covered in an emergency department. Follow-up care or routine care provided in a Hospital emergency department is not covered.

- Emergency Hospital Admissions. In the event a covered person is admitted to the Hospital, the covered person or someone acting on his or her behalf must notify Cigna at the telephone number listed on the ID card within 48 hours of admission, or as soon as is reasonably possible.

- Payments Relating to Emergency Services Rendered. The amount paid to non-Participating Providers for Emergency Services will be the greater of: the amount that Cigna negotiated with Participating Providers for the Emergency Services received (and if more than one amount
is negotiated, the median of the amounts); 100% of the allowed amount for services provided by a non-Participating Provider (i.e., the amount Cigna would pay in the absence of any cost-sharing that would otherwise apply for services of non-Participating Providers; or the amount that would be paid under Medicare. These amounts exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.

- **Urgent Care.** Urgent Care may be obtained from a Participating Provider or a Participating Urgent Care center, as well as from a non-Participating Urgent Care center or Physician. **If Urgent Care results in an Emergency admission, the standards for Emergency Hospital admissions described above apply.**

- charges made by a Physician or a Psychologist for professional services.

- charges made by a Nurse, other than a member of your family or your Dependent’s family, for professional nursing service.

- charges made for anesthetics and their administration; chemotherapy; blood transfusions; oxygen and other gases and their administration.

- charges made for X-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

- charges made for interruption of pregnancy, as follows: therapeutic abortions; non-therapeutic abortions in cases of rape, incest or fetal malformation; elective abortions.

- **Preventive Care.** The following services are covered for the purpose of promoting good health and early detection of disease. Preventive services are not subject to cost-sharing (Copayments, Deductibles, and Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”), or if the items or services have a “A” or “B” rating from the United States Preventive Services Task Force (“USPSTF”), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (“ACIP”). However, cost-sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply. Contact Cigna at the number shown on your ID card or visit www.mycigna.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an “A” or “B” rating from the USPSTF, and immunizations recommended by ACIP.

- **Well-Baby and Well-Child Care.** Coverage is provided for well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. Preventive Care and screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF are also covered. If the schedule of well-child visits referenced above permits one well-child visit per calendar year, Cigna will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also covered. This benefit is provided to covered persons from birth through attainment of age 19 and is not subject to Copayments, Deductible or Coinsurance when provided by a Participating Provider.

- **Adult Annual Physical Examinations.** Annual physical examinations and preventive care and screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF are covered. Examples of items or services with an “A” or “B” rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening and diabetes screening. A complete list of the covered preventive services is available on our website at www.mycigna.com, or will be mailed upon request.

Covered persons are eligible for a physical exam once every contract year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

- **Adult Immunizations.** Adult immunizations as recommended by ACIP are covered. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

- **Well-Woman Examinations.** Well-woman examinations which consist of routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear are covered. Preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from
USPSTF are also covered. A complete list of the covered preventive services is available on our website at www.mycigna.com, or will be mailed upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

- **Mammograms.** Mammograms for the screening of breast cancer are covered as follows:
  - one baseline screening mammogram for women age 35 through 39;
  - one baseline screening mammogram annually for women age 40 and over.

If a woman of any age has a history of breast cancer or her first degree relative has a history of breast cancer, mammograms as recommended by her provider are covered.

However, in no event will more than one preventive screening, per calendar year, be covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may be less frequent than the above schedule, and when provided by a Participating Provider.

Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to Copayments, Deductibles or Coinsurance.

- **Family Planning & Reproductive Health Services.**

  Family planning services which consist of FDA-approved contraceptive methods prescribed by a provider, not otherwise covered under the Prescription Drug benefit in the Certificate and counseling on use of contraceptives, related topics and sterilization procedures for women are covered. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

  Vasectomies are also covered subject to Copayments, Deductibles or Coinsurance.

  Services related to the reversal of elective sterilizations are not covered.

- **Bone Mineral Density Measurements or Testing.** Bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes are covered. Coverage of Prescription Drugs is subject to the Prescription Drug section of the Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. A covered person will also qualify for coverage of bone mineral density measurements and testing if he or she meets any of the following:
  - previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
  - with symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
  - on a prescribed drug regimen posing a significant risk of osteoporosis; or
  - with lifestyle factors to a degree as posing a significant risk of osteoporosis; or
  - with such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

Bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF are also covered.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

- **Screening for Prostate Cancer.** An annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors is covered. Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer is also covered.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

- charges made for surgical or nonsurgical treatment of Temporomandibular Joint Dysfunction.
- charges for preadmission testing ordered by a Physician performed in a Hospital prior to scheduled surgery in the same Hospital, provided that: the tests are necessary for and consistent with the diagnosis and treatment of the condition.

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for which surgery is to be performed; reservations for a Hospital bed and operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the Hospital for the tests.
• charges for second opinions, as follows:
  • second cancer opinion. Coverage is provided for a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.
  • second surgical opinion. Coverage is provided for a second surgical opinion by a qualified Physician on the need for surgery. Additionally, Cigna may require a second surgical opinion before pre-authorizing a surgical procedure. When Cigna requests the second opinion, there is no cost to you. However, the Cigna-required second opinion must be given by a board certified Specialist who personally examines you. If the first and second opinions do not agree, you may obtain a third opinion. The second and third surgical opinion consultants may not perform the surgery on you.
  • second opinions in other cases. There may be other instances when you will disagree with a provider’s recommended course of treatment. In such cases, you may request that Cigna designate another provider to render a second opinion. If the first and second opinions do not agree, Cigna will designate another provider to render a third opinion. After completion of the second opinion process, Cigna will preauthorize or approve, as appropriate, covered services supported by a majority of the providers reviewing your case.
• charges for inpatient coverage with respect to the treatment of breast cancer, for a period of time determined by you and the attending Physician to be appropriate following a mastectomy, lumpectomy or lymph node dissection, for the treatment of breast cancer.
• charges in connection with maternity care provided by a Physician or nurse midwife, nurse practitioner, Hospital or birthing center. Coverage includes prenatal care (including one visit for genetic care), postnatal care, delivery, and complications of pregnancy. In order for services of a nurse midwife to be covered, the nurse midwife must be licensed pursuant to Article 140 of the Education Law, practicing consistent with Section 6951 of the Education Law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health Law. We will not pay for duplicative routine services provided by both a nurse midwife and a Physician. The cost of renting or purchasing one breast pump per pregnancy for the duration of breast feeding is also covered.
• charges made for inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. Cigna will also cover any additional days of such care that it determines are Medically Necessary. In the event the other elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum coverage period, Cigna will cover a home care visit. The home care visit will be provided within 24 hours after the mother’s discharge, or the time of the mother’s request, whichever is later. Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any cost-sharing amounts in The Schedule that apply to home care benefits.
• charges made for diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the Education Law as described below:
  • supplies. Coverage is provided for the following equipment and related supplies for the treatment of diabetes when prescribed by your Physician or other provider legally authorized to prescribe:
    • Acetone Reagent Strips
    • Acetone Reagent Tablets
    • Alcohol or Peroxide by the pint
    • Alcohol Wipes
    • All insulin preparations
    • Automatic Blood Lance Kit
    • Blood Glucose Kit
    • Blood Glucose Strips (Test or Reagent)
    • Blood Glucose Monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
    • Cartridges for the visually impaired
    • Diabetes data management systems
    • Disposable insulin and pen cartridges
    • Drawing-up devices for the visually impaired
    • Equipment for use of the Pump
    • Glucose Acetone Reagent Strips
- Glucose Reagent Strips
- Glucose Reagent Tape
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin Cartridge Delivery
- Insulin infusion devices
- Insulin Pump
- Lancets
- Oral agents such as glucose tablets and gels
- Glucagon for injection to increase blood glucose concentration
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

- self-management education. Diabetes self-management education is education designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition including information on proper diets. Cigna covers education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in your symptoms or condition which necessitates a change in your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:
  - by a Physician, other health care provider authorized to prescribe under Title 8 of the Education Law, or their staff during an office visit;
  - upon the referral of your Physician or other health care provider authorized to prescribe under Title 8 of the Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
  - education will also be provided in your home when Medically Necessary.

- Limitations. The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for you. Cigna covers only basic models of blood glucose monitors unless you have special needs relating to poor vision or blindness.

- charges for enteral formulas, whether administered orally or via feeding tube, for home use for the treatment of: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies. The Physician must issue a written order stating that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for individuals who are or will become malnourished or suffer from disorders which, if left untreated, cause chronic physical disability, mental retardation or death. Covered expenses will also include modified solid food products that are low protein or which contain modified protein, which are Medically Necessary. Such coverage for any calendar year or continuous 12-month period will be limited to $2,500, applicable to Out-of-Network benefits only.

- charges for the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Cigna to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, “autism spectrum disorder” means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

- Screening and Diagnosis. Cigna covers assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

- Assistive Communication Devices. Cigna covers a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, Cigna covers the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if you are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide you with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices; Cigna will only cover devices that generally are not useful to a person in the absence of a communication impairment. We will not cover items, such as, but not limited to, laptops, desktop, or tablet computers. Cigna covers software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-
generating device. Installation of the program and/or technical support is not separately reimbursable. Cigna will determine whether the device should be purchased or rented.

Repair, replacement fitting and adjustments of such devices are covered when made necessary by normal wear and tear or significant change in your physical condition. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered. Coverage will be provided for the device most appropriate to your current functional level.

- **Behavioral Health Treatment.** Cigna covers counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. Cigna will provide such coverage when provided by a licensed Provider. Cigna covers applied behavior analysis when provided by an applied behavior analysis provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

Cigna's coverage of applied behavior analysis services is limited to 680 hours per Covered person per plan year.

- **Psychiatric and Psychological Care.** Cigna covers direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.

- **Therapeutic Care.** Cigna covers therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.

- **Pharmacy Care.** Cigna covers Prescription Drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug Benefits under this Certificate.

Cigna will not cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the Public Health Law, an individualized education plan under Article 89 of the Education Law, or an individualized service plan pursuant to regulations of the Office for Persons With Developmental Disabilities shall not affect coverage under the Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Deductible, Copayment, or Coinsurance provisions under this Certificate for similar services. For example, any Deductible, Copayment, or Coinsurance that applies to physical therapy visits generally will also apply to physical therapy services covered under this benefit; and any Deductible, Copayment, or Coinsurance for Prescription Drugs generally will also apply to Prescription Drugs covered under this benefit. Any Deductible, Copayment, or Coinsurance that applies to office visits will apply to assistive communication devices covered under this paragraph.

Nothing in this Certificate shall be construed to affect any obligation to provide coverage for otherwise-covered services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

- **charges made for end of life acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients when a Covered Person is diagnosed with advanced cancer and has fewer than 60 days to live. Your attending Physician and the facility’s medical director must agree that your care will be appropriately provided at the facility. If Cigna disagrees with your admission to the facility, Cigna has the right to initiate an Expedited Appeal to an External Review agent. Cigna will cover and reimburse the facility for your care, subject to any applicable limitations in the Certificate, until the External Appeal Agent renders a decision in Cigna's favor.**
Cigna will reimburse non-Participating Providers for this end of life care as follows:

- Cigna will reimburse a rate that has been negotiated between Cigna and the provider.
- If there is no negotiated rate, Cigna will reimburse Acute care at the facility’s current Medicare acute care service rates.
- Or if it is an alternate level of care, Cigna will reimburse at 75% of the appropriate Medicare rates.

Limitations/Terms of Coverage:

- when you are receiving inpatient care in a Hospital or other facility as described above, Cigna will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies you take home from the Facility. If you occupy a private room, and the private room is not Medically Necessary, Cigna’s coverage will be based on the facility’s maximum semi-private room charge. You will have to pay the difference between that charge and the charge for the private room.
- Cigna does not cover radio, telephone and television expenses, or beauty or barber services.
- Cigna does not cover any charges incurred after the day you are advised that it is no longer Medically Necessary for you to receive inpatient care, unless Cigna’s denial is overturned by an External Appeal Agent.

Clinical Trials

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

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

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

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

The clinical trial must meet the following requirements:

The study or investigation must:

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

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

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

Routine patient care costs do not include:

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

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

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

Genetic Testing

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

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a
genetically-linked inheritable disease when the results will impact clinical outcome; or

- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

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

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing.

**Nutritional Evaluation**

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

**Internal Prosthetic/Medical Appliances**

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

**Orthognathic Surgery**

- orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not correct, provided:
  - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
  - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

**Home Health Services**

Home health services for care provided in a covered person’s home by a Home Health Agency certified or licensed by the appropriate state agency are covered. The care must be provided pursuant to your Physician’s written treatment plan and must be in lieu of hospitalization or confinement in a Skilled Nursing Facility. Home care includes (i) part-time or intermittent nursing care by or under the supervision of a Registered Professional Nurse (RN), (ii) part-time or intermittent services of a home health aide, (iii) physical, occupational or speech therapy provided by the Home Health agency, and (iv) medical supplies, drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health agency to the extent such items would have been covered during a hospitalization or confinement in a Skilled Nursing Facility. Home health services are limited as shown in the Schedule. Each visit by a member of the Home Health agency is considered one visit. Each visit of up to four hours by a home health aide is one visit. Please note: Any rehabilitation services received under this benefit will not reduce the amount of services available under Short-term Rehabilitative Therapy.

**Hospice Care Services**

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
Mental Health Care and Substance Abuse Services

Please refer to The Schedule for cost-sharing requirements, day or visit limits, and any preauthorization or referral requirements that apply to these benefits.

Mental Health Care Services

Inpatient Services: Cigna covers inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. However, coverage for inpatient services for mental health care is limited to facilities as defined by New York Mental Hygiene Law § 1.03 subdivision 10.

Outpatient Services: Cigna covers outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in New York; a licensed clinical social worker who meets the requirements of NY Ins. Law §§ 3221(l)(4)(D), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.

Limitations/Terms of Coverage:

- Cigna will not cover benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual’s appearance is justified by the individual’s mental health needs.
- Cigna will not cover mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the Office of Children and Family Services.
- Cigna will not cover services solely because they are ordered by a court.

Substance Abuse Services

Inpatient Services: Cigna covers inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

Outpatient Services: Cigna covers outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by Physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation; and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.
Cigna also covers outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for substance use, and/or dependence. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

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

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

Prostheses/Prosthetic Appliances and Devices
Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts.

Orthoses and Orthotic Devices
Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:
- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses;
  - semirigid prefabricated and flexible orthoses; and
• rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.

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

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

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

The following braces are specifically excluded: Copes scoliosis braces.

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

Coverage for replacement of external prosthetic appliances and devices is limited to the following:
• replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

• Coverage for replacement is limited as follows:
  • no more than once every 24 months for persons 19 years of age and older;
  • no more than once every 12 months for persons 18 years of age and under; and
  • replacement due to a surgical alteration or revision of the site.

Repairs and necessary maintenance of purchased equipment not otherwise provided under manufacturer’s warranty or purchase agreement are also covered.

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.

Infertility Services
• charges made for services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction. Such coverage is available as follows:
  • Basic Infertility Services. Basic Infertility Services will be provided to a covered person who is an appropriate candidate for infertility treatment. In order to determine eligibility, Cigna will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, the covered person must be between the ages of 21 and 44 (inclusive) in order to be a candidate for these services. Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, endometrial biopsy, pelvic ultrasound, hysterosalpingogram, sono-hysterogram, testis biopsy, blood tests and medically appropriate treatment of ovulatory dysfunction. Additional tests may be covered if the tests are determined to be Medically Necessary.
  • Comprehensive Infertility Services. If the basic Services do not result in increased fertility, Cigna covers Comprehensive Infertility Services. These services include: ovulation induction and monitoring; pelvic
ultrasound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.

- Additional Infertility Services. Cigna will also cover: infertility drugs which are administered or provided by a Physician, sperm washing or preparation; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT).

- Covered Expenses for Infertility Services provided for or in connection with gamete intrafallopian transfer (GIFT); In vitro fertilization (IVF); or zygote intrafallopian transfer (ZIFT) will be limited to $10,000 per person per lifetime.

Exclusions and Limitations:
- cost for an ovum donor or donor sperm.
- sperm storage costs.
- cryopreservation and storage of embryos.
- ovulation predictor kits.
- reversal of tubal ligations. Reversal of vasectomies.
- all costs for and relating to surrogate motherhood (maternity services are provided for covered persons acting as surrogate mothers).
- sex change procedures.
- cloning.
- medical and surgical procedures that are experimental or investigational unless Cigna's denial of such procedure is overturned by an External Appeal Agent.
- all services must be provided by providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

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

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

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

Services that are provided by a chiropractic Physician are not covered under Short-Term Rehabilitative Therapy (see the section Chiropractic Care Services for coverage details). For purposes of this section, custodial care services means help in transferring, eating, dressing, bathing, toileting, and other such related activities.

Chiropractic Care Services
Cigna covers charges for chiropractic care when performed by a Doctor of Chiropractic (“Chiropractor”) in connection with correction or detection by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference and effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column. This includes assessment, manipulation and any modalities. Any Medically Necessary laboratory tests will be covered in accordance with the terms and conditions of this Certificate.

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

**Reconstructive Surgery**

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

**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 or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

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

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

**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.

**Conversion Right To New Policy After Termination**

You have the right to convert to a new Policy if coverage under this Certificate terminates under the circumstances described below.
**Termination of the Group Policy.** If the Group Policy between Cigna and the Group Policyholder is terminated as set forth in the Policy, and the Group Policyholder has not replaced the coverage for the Group with similar and continuous health care coverage, whether insured or self-insured, you are entitled to purchase a new Policy as direct payment members.

**If You Are No Longer Covered in a Group.** If your coverage terminates under this Certificate because you are no longer a member of a Group, you are entitled to purchase a new Policy as a direct payment member.

**On the Death of the Employee.** If coverage terminates under this Certificate because of the death of the Employee, the Employee’s Dependents are entitled to purchase a new Policy as direct payment members.

**Termination of Your Marriage.** If a Spouse’s coverage terminates under this Certificate because the Spouse becomes divorced from the Employee or the marriage is annulled, that former Spouse is entitled to purchase a new Policy as a direct payment member.

**Termination of Coverage of a Child.** If a Dependent child’s coverage terminates under this Certificate because the child no longer qualifies as a Dependent child, the child is entitled to purchase a new Policy as a direct payment member.

**Termination of Your Temporary Continuation of Coverage.** If coverage terminates under this Certificate because you are no longer eligible for continuation of coverage, you are entitled to purchase a new Policy as a direct payment member.

**Termination of Your Young Adult Coverage.** If a Dependent child’s young adult coverage terminates under this Certificate, the child is entitled to purchase a new Policy as a direct payment member.

**When to Apply for the New Contract.** If you are entitled to purchase a new Policy as described above, you must apply to Cigna for the new Policy within 60 days after termination of coverage under this Certificate. You must also pay the first Premium of the new Policy at the time you apply for coverage.

**The New Policy.** Cigna will offer you an individual direct payment Policy at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. You may choose among any of the four Policies offered by Cigna. However, the coverage may not be the same as your current coverage. However, if Cigna determines that you do not reside in New York State, Cigna may issue you or your family members coverage on a form that we use for conversion in that state.

**When Conversion is Not Available.** Cigna will not issue you an individual direct payment Policy if the issuance of the new Policy will result in overinsurance or duplication of benefits according to the standards Cigna has on file with the Superintendent of the New York State Department of Financial Services.
Prescription Drug Benefits

The Schedule

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

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

Charges
The term Charges means the amount charged by the Insurance Company to the plan when the Pharmacy is a Participating Pharmacy, and it means the actual billed charges when the Pharmacy is a non-Participating Pharmacy.

Copayments
Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies. **NOTE**: If the cost of a covered Prescription Drug or Related Supply is less than the copayment for that Prescription Drug or Related Supply, you or your Dependent are responsible for the lesser amount.

Calendar Year Deductible
Deductibles are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies. These Deductibles are in addition to any copayments or coinsurance. Once the Deductible maximum shown in The Schedule has been reached you and your family need not satisfy any further Prescription Drug Deductible for the rest of that year.

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

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>PARTICIPATING PHARMACY</th>
<th>Non-PARTICIPATING PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>$125 per person</td>
<td>$125 per person</td>
</tr>
<tr>
<td>Family</td>
<td>$375 per family</td>
<td>$375 per family</td>
</tr>
</tbody>
</table>

**Note:**
Generic Drugs are not subject to the Deductible

<table>
<thead>
<tr>
<th>Out-of-Pocket Maximum</th>
<th>PARTICIPATING PHARMACY</th>
<th>Non-PARTICIPATING PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$4000 per person</td>
<td>$4000 per person</td>
</tr>
<tr>
<td>Family</td>
<td>$8000 per family</td>
<td>$8000 per family</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>PARTICIPATING PHARMACY</td>
<td>Non-PARTICIPATING PHARMACY</td>
</tr>
<tr>
<td>---------------------------------</td>
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<td>----------------------------</td>
</tr>
<tr>
<td>Retail Prescription Drugs</td>
<td>The amount you pay for each 30-day supply</td>
<td>The amount you pay for each 30-day supply</td>
</tr>
<tr>
<td>Medicaitions required as part of preventive care services (detailed information is available at <a href="http://www.healthcare.gov">www.healthcare.gov</a>) are covered at 100% with no copayment or deductible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic* drugs on the Prescription Drug List</td>
<td>No charge after $15 copay</td>
<td>30%</td>
</tr>
<tr>
<td>Tier 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent</td>
<td>No charge after $30 copay after pharmacy deductible</td>
<td>30% after pharmacy deductible</td>
</tr>
<tr>
<td>Tier 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List</td>
<td>No charge after $55 copay after pharmacy deductible</td>
<td>30% after pharmacy deductible</td>
</tr>
</tbody>
</table>

* Designated as per generally-accepted industry sources and adopted by the Insurance Company

<table>
<thead>
<tr>
<th>Home Delivery Prescription Drugs</th>
<th>The amount you pay for each 90-day supply</th>
<th>The amount you pay for each 90-day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaitions required as part of preventive care services (detailed information is available at <a href="http://www.healthcare.gov">www.healthcare.gov</a>) are covered at 100% with no copayment or deductible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic* drugs on the Prescription Drug List</td>
<td>No charge after $15 copay</td>
<td>In-network coverage only</td>
</tr>
<tr>
<td>Tier 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent</td>
<td>No charge after $30 copay after pharmacy deductible</td>
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<td>Tier 3</td>
<td></td>
<td></td>
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<td>Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List</td>
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</tr>
</tbody>
</table>

* Designated as per generally-accepted industry sources and adopted by the Insurance Company
**Prescription Drug Benefits**

**For You and Your Dependents**

**Covered Expenses**

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

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

Covered Expenses include charges for a drug that has been prescribed for the treatment of a type of cancer for which it has not been approved by the Food and Drug Administration (FDA) only if such drug is recognized for the treatment of the specific type of cancer for which the drug has been prescribed in one of the established reference compendia: the American Hospital Formulary Service-Drug Information (AHFS-DI); the National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard’s Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services (CMS); or recommended by a review article or editorial comment in a major peer-reviewed professional journal.

**Limitations**

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Pharmacy unless limited by the drug manufacturer's packaging; or
- up to a consecutive 90-day supply at a home delivery Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

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

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to Cigna to request a prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

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

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

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

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

**Your Payments**

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

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

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

**Exclusions**

No payment will be made for the following expenses:

- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee, unless Medically Necessary and approved by Cigna;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription and nonprescription supplies (such as ostomy supplies), devices (other than FDA approved medicines or devices prescribed to detect or treat bone mineral density conditions), and appliances other than Related Supplies;
- implantable contraceptive products;
- prescription vitamins (other than prenatal vitamins), dietary supplements, unless state or federal law requires coverage of such drugs;
- diet pills or appetite suppressants (anorectics), unless determined to be Medically Necessary and approved by Cigna;
- prescription smoking cessation products, unless determined to be Medically Necessary and approved by Cigna;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products, unless determined to be Medically Necessary and approved by Cigna;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance, unless determined to be Medically Necessary and approved by Cigna;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue;
- any drugs that are experimental or investigational as described under the Medical “Exclusions” section of your certificate.

Other limitations are shown in the Medical “Exclusions” section of your certificate.

**Reimbursement/Filing a Claim**

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

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

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

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

Exclusions and Limitations of Coverage

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:

- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in functional defect.
- foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
- treatment provided in a government hospital.
- benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers’ compensation, employers’ liability or occupational disease law.
- services rendered and separately billed by employees of hospitals, laboratories or other institutions.
- services performed by a member of the covered person’s immediate family.
- dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.
- hearing aids.
- eyeglasses and examination for the prescription or fitting thereof.
- rest cures and custodial care.
- expenses incurred outside the United States, its possessions or the countries of Canada and Mexico, other than expenses for Medically Necessary urgent or emergent Care while temporarily traveling abroad.

Exclusions and Expenses Not Covered Unless Medically Necessary

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

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- 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.
- 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.
- dental implants for any condition.
- for or in connection with experimental, investigational or unproven services. However, Cigna will cover an experimental or investigational treatment approved by an external appeal agent. If the external appeal agent approved coverage of an experimental or investigational treatment that is part of a clinical trial, Cigna will only cover the costs of services required to provide treatment to you according to the design of the trial. Cigna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or the costs which would not be covered under this plan for nonexperimental or noninvestigational treatments provided in such clinical trial.
Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

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

- charges made for drugs and implanted/injected devices for contraception.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- 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.

Limitations of Coverage

No payment will be made for expenses incurred for you or any one of your Dependents:
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, and elastic stockings.
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- expenses denied by a Primary Plan because treatment was received from a nonparticipating provider.
- 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.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary, except as specified in any certification requirement shown in this plan.

Coordination of Benefits

This section applies when you or any one of your Dependents also have group health coverage with another plan. When you or any one of your Dependents receives a covered service, Cigna will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This prevents duplicate payments and overpayments.

Definitions

“Allowable expense” is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

“Plan” is other group health coverage with which Cigna will coordinate benefits. The term “plan” includes:

- Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
- Medical benefits coverage, in group and individual automobile “no-fault” and traditional liability “fault” type contracts.
- Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.
“Primary plan” is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: the plan has no order of benefits rules or its rules differ from those required by regulation; or all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

“Secondary plan” is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Rules to Determine Order of Payment

The first of the rules listed below in the following six paragraphs that applies will determine which plan will be primary:

- If the other plan does not have a provision similar to this one, then the other plan will be primary.
- If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.
- If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
- If a child is covered by both parents’ plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child’s health care expenses:
  - The plan of the parent who has custody will be primary.
  - If the parent with custody has remarried, and the child is also covered as a child under the step-parent’s plan, the plan of the parent with custody will pay first, the step-parent’s plan will pay second, and the plan of the parent without custody will pay third.
  - If a court decree between the parents says which parent is responsible for the child’s health care expenses, then that parent’s plan will be primary if that plan has actual knowledge of the decree.
- If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
- If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed the maximum available benefit for each covered service. Also, the amount Cigna pays will not be more than the amount it would pay if it were primary. As each claim is submitted, Cigna will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Necessary Information

Cigna may release or receive information that it needs to coordinate benefits. Cigna does not need to tell anyone or receive consent to do this. Cigna is not responsible to anyone for releasing or obtaining this information. You [or your covered Dependents] must give Cigna any needed information for coordination purposes, in the time frame requested.

Our Right to Recover Overpayment

If Cigna made a payment as a primary plan, you agree to pay Cigna any amount by which Cigna should have reduced its payment. Also, Cigna may recover any overpayment from the primary plan or the Provider receiving payment and you agree to sign all documents necessary to help recover any overpayment.

Coordination with “Always Excess,” “Always Secondary,” or “Non-Complying” Plans

Cigna will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

- If this Certificate is primary, as defined in this section, Cigna will pay benefits first.
- If this Certificate is secondary, as defined in this section, Cigna will pay only the amount it would pay as the secondary insurer.

If Cigna requests information from a non-complying plan and does not receive it within 30 days, Cigna will calculate the amount it should pay on the assumption that the non-complying plan and this Certificate provide identical benefits.
When the information is received, Cigna will make any necessary adjustments.

**Medicare Eligibles**

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

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

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

(c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

Cigna will assume the amount payable under:

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

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

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

**Domestic Partners**

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

**Payment of Benefits**

**To Whom Payable**

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

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

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.

**Time of Payment**

Benefits will be paid by Cigna not more than 60 days after it receives due proof of loss.

**Recovery of Overpayment**

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

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

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

**Termination of Insurance**

**Employees**

Your insurance will cease on the earliest date below:

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

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

**Temporary Layoff or Leave of Absence**

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date as determined by the Employer.

**Injury or Sickness**

If your Active Service ends due to an Injury or Sickness, your insurance will be continued until the date as determined by the Employer.

**Retirement**

If your Active Service ends because you retire, and you are under age 65, your insurance will be continued until the earlier of: a) the date on which your Employer stops paying premium for you or otherwise cancels the insurance; or b) your 65th birthday.

**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 date as defined by the Employer for a surviving spouse.
- 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.

**Continuation Required By New York State Law for You and Your Dependents**

New York state law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment. New York State law also enables your Dependents to continue health insurance if their coverage ceases due to your death or entitlement to Medicare, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to New York state law, regulations and interpretations.

If your, and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. You and your Dependents must elect to continue insurance within 60 days from the later of: the date of a reduction of your work hours or your termination of employment; or the date notice of the right to continue insurance is sent via first class mail. Such insurance will not be continued by Cigna for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

- 36 months after termination of coverage for any qualifying event named above;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date you become entitled to Medicare, following your enrollment in Medicare; or
- the effective date of coverage under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.
Conversion Available Following Continuation

If your or your Dependent's Continuation ends due to the expiration of the maximum 18- or 36-month continuation period, whichever applies, you or your Dependent will be entitled to convert to the insurance in accordance with the Medical Conversion benefit then available to Employees and their Dependents.

Interaction with Other Continuation Benefits

A person who is eligible to continue insurance under this continuation required by New York state law; or any other continuation of insurance provided in this Certificate may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of the continuation required by New York state law.

Special Continuation of Medical Insurance for Military Reservists and Their Dependents

If you are a reservist whose Medical Insurance would otherwise cease because you are called to active military duty, you may continue Medical Insurance for yourself and your Dependents, upon payment of the required premium to your Employer. You may continue the insurance for up to 4 years, but not beyond the earliest of the following dates:

- the last day for which the required premium has been paid;
- the date you or your Dependent becomes eligible for insurance under another group policy, other than the Civilian Health and Medical Program of the Uniformed Services;
- the date you become eligible for Medicare.

The continuation of Medical Insurance will provide the same benefits as those provided to any similarly situated person insured under the policy who has not been called to active duty.

Provisions Regarding Notification and Election of Special Continuation

You or your Dependent must request continuation, in writing, within 60 days of being called to active duty. You must also pay the required premium to the Employer.

Conversion Available Following Continuation

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

Reinstatement of Medical Insurance for Military Reservists and Their Dependents

If you return to employment when your active military duty as a reservist ends, you are entitled to the reinstatement of medical insurance for yourself and your Dependents. Such reinstatement will be without the application of:

- a new waiting period. However, the remainder of a waiting period not satisfied before active military duty began may still be applied.
- the Pre-existing Condition Limitation to any new condition that you or your Dependent may have developed while coverage was interrupted due to active military duty. However, the Pre-existing Condition Limitation may still be applied to conditions resulting directly from military duty.

"Reservist" means a member of a reserve component of the armed forces of the United States. "Reservist" includes a member of the National Guard whose active duty is extended at a time when the president is authorized to order: units of the ready reserve; or members of a reserve component, to active duty. Such additional active duty must be at the request and for the convenience of the federal government. It does not include: reservists entering active duty for the purpose of training or determining physical fitness; or reservists who have served more than 4 years of active duty.

Provisions Applicable to Reinstatement

If you return to employment after your discharge, you may reinstate your medical insurance. You must notify your Employer that you elect reinstatement within 90 days from your date of discharge. Such reinstatement will be retroactive to your date of discharge.

Continuation of Coverage under New York Law for Dependent Children Who Have Met the Limiting Age

A Dependent child of a Covered Person who meets the limiting age for coverage of a Dependent, is eligible to continue coverage for himself through age 29, provided he meets all of the following criteria for this continuation coverage:

- is a Covered Person’s Dependent child as defined under this plan (other than any requirement requiring financial dependence on a Covered Person); and
- has reached the limiting age as specified under this plan, but has not yet reached his 30th birthday; and
- is unmarried; and
- lives, works, or resides in New York or within Cigna’s service area; and
- is not insured or eligible for coverage under any employee health benefits plan, whether insured or self-insured; and
- is not covered under Medicare.
To obtain continued coverage under this provision, a written election for continuation coverage, together with the first premium payment required to establish premium payment on a monthly basis, in advance, must be made:

- within 60 days following the date coverage would otherwise terminate due to the Dependent child reaching the limiting age specified under this plan; or
- within 60 days after meeting the criteria for continued coverage described above when coverage for the Dependent child previously terminated; or
- during an annual 30-day open enrollment period.

For 12 months after September 1, 2009, continuation coverage under this provision may be elected for a Dependent child whose coverage terminated under the terms of this plan prior to September 1, 2009.

The amount of the required premium payment for the continued coverage must be paid to the Employer on the due date of each payment, but not more frequently than on a monthly basis, in advance. Any premium received within the 30-day period after the due date will be considered timely.

The effective date of the continued coverage will be the date coverage would otherwise have terminated, for elections made within 60 days following the termination date. For any Dependent child electing to resume coverage during an annual open enrollment period or during the 12-month initial open enrollment period after September 1, 2009, the effective date of the continued coverage shall be no later than 30 days after the election and payment of first premium.

Continuation coverage for the Dependent child must be identical to the coverage provided under the plan for the Covered Person through whom the Dependent child is eligible. If coverage is modified under the plan for any group of similarly situated employees or members, then the continuation coverage for the Dependent child must be modified in the same manner.

Continuation coverage for a Dependent child under this provision will end with the first of the following events to occur:

- The date the Dependent child no longer meets the criteria for continued coverage.
- The end of the period for which premium payments were made, if premium is not paid by any due date or within the 30-day grace period.
- The date on which this policy is terminated and is not replaced by coverage under another group policy.

**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.

**Medical Benefits Extension**

Any expense incurred within one year after a person's Medical Expense Insurance ceases will be deemed to be incurred while he is insured if such expense is for an Injury or Sickness which causes him to be Totally Disabled from the day his insurance ceases until that expense is incurred.

The terms of this Medical Benefits Extension will not apply to: a child born as a result of a pregnancy which exists when a person's benefits cease; or any person when he becomes insured under another group policy for medical benefits.

**Totally Disabled**

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

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

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

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.
Federal Requirements

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

Notice of Provider Directory/Networks

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

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

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

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.

Qualified Medical Child Support Order Defined (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.

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

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

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

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

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

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

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

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

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

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

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

A. Coverage Elections

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

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

B. Change of Status

A change in status is defined as:

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

C. Court Order

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

D. Medicare or Medicaid Eligibility/Entitlement

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

E. Change in Cost of Coverage

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

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

F. Changes in Coverage of Spouse or Dependent Under Another Employer’s Plan

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

G. Reduction in work hours

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

H. Enrollment in Qualified Health Plan (QHP)

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

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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.

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.

Women’s Health and Cancer Rights Act (WHCRA)

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

Group Plan Coverage Instead of Medicaid

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

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

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

Continuation of Health Insurance During Leave

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

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

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

Reinstatement of Canceled Insurance Following Leave

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

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

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

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

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee’s military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.
Continuation of Coverage

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

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

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

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

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

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

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

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

Medical Necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below:

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

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

Preservice Medical Necessity Determinations

When you or your representative request a required Medical Necessity determination prior to care, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna’s control, Cigna will notify you or your representative within 15 days after receiving your request.

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

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

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

Claim Determination Procedures under ERISA

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

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.

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your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

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

Concurrent Medical Necessity Determinations

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

Postservice Medical Necessity Determinations

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

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan’s review procedures and the time limits applicable, including a statement of a claimant’s rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a “qualifying event” that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan’s coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following
qualifying events if the event would result in a loss of coverage under the Plan:

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

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

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

**Who is Entitled to COBRA Continuation?**

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

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

**Secondary Qualifying Events**

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

**Disability Extension**

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

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

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

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

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

**Medicare Extension for Your Dependents**

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

**Termination of COBRA Continuation**

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

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer’s policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
• after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
• any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).
Moving Out of Employer’s Service Area or Elimination of a Service Area
If you and/or your Dependents move out of the Employer’s service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer’s service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer’s Notification Requirements
Your Employer is required to provide you and/or your Dependents with the following notices:
• An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse’s) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
• A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  • if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  • if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  • in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage
The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If 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.

Conversion Available Following Continuation

If your or your Dependents’ COBRA continuation ends due to the expiration of the maximum 18-, 29- or 36-month period, whichever applies, you and/or your Dependents may be entitled to convert to the coverage in accordance with the Medical Conversion benefit then available to Employees and the Dependents. Please refer to the section titled “Conversion Privilege” for more information.

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.
ERISA Required Information

The name of the Plan is:
   Pace University Medical Plan

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:
   Pace University
   235 Elm Road
   Briarcliff Manor, NY 10510
   914-923-2730

Employer Identification Number (EIN):
   135562314

Plan Number:
   510

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 06/30.

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.

**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.

**Grievance**

Grievances. Cigna’s Grievance procedure applies to any issue not relating to Medical Necessity or experimental or investigational determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding Cigna’s administrative policies or access to providers.
Filing a Grievance. You can contact Cigna by phone at the toll-free number on your Benefit Identification card, explanation of benefits or claim form or in writing to file a Grievance to:

Cigna
National Appeals Unit (NAU)
PO Box 188011
Chattanooga, TN 37422

You may submit an oral Grievance in connection with a denial of a referral or a covered benefit determination. We may require that you sign a written acknowledgement of your oral Grievance, prepared by us. You have or your designee has up to 180 calendar days from when your received the decision you are asking us to review to file the Grievance.

When we receive your Grievance, we will mail an acknowledgement letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and we will take no discriminatory action because of your issue. We have a process for both standard and expedited Grievances, depending on the nature of your inquiry.

Grievance Determination. Qualified personnel will review your Grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the Grievance and notify you within the following time frames:

- Expedited/Urgent Grievances: By phone within the earlier of 48 hours of receipt of the necessary information or 72 hours of receipt of your Grievance. Written notice will be provided within 72 hours of receipt of your Grievance.
- Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.) In writing, within 15 calendar days of receipt of your Grievance.
- Post-Service Grievances: (A claim for a service or a treatment that has already been provided.) In writing, within 30 calendar days of receipt of your Grievance.
- All Other Grievances: (That are not in relation to a claim or request for service.) In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of your Grievance.

Grievance Appeals. If you are not satisfied with the resolution of your Grievance, you or your designee may file an Appeal by phone or in writing to:

Cigna
National Appeals Unit (NAU)
PO Box 188011
Chattanooga, TN 37422

You have up to 60 business days from receipt of the Grievance determination to file an Appeal. When we receive your Appeal, we will mail an acknowledgement letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling your Appeal, and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify you in writing within the following time frames:

- Expedited/Urgent Grievances: The earlier of 2 business days of receipt of the necessary information or 72 hours of receipt of your Appeal.
- Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.) 15 calendar days of receipt of your Appeal.
- Post-Service Grievances: (A claim for a service or a treatment that has already been provided.) 30 calendar days of receipt of your Appeal.
- All Other Grievances: (That are not in relation to a claim or request for service.) 30 business days receipt of all necessary information to make a determination.

If you remain dissatisfied with our Appeal determination, or at any other time you are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov
If you need assistance filing a Grievance or Appeal, you may also contact the state independent Consumer Assistance program at:

Community Health Advocates
105 East 22nd Street
New York, NY 10010
or call toll-free: 1-888-614-5400
or email cha@cssny.org

External Appeal

I. Your Right to an External Appeal

In some cases, you have a right to an External Appeal of a denial of coverage. Specifically, if we have denied coverage on the basis that a service does not meet our requirements for Medical Necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you or your representative may Appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct those Appeals.

In order for you to be eligible for an External Appeal you must meet the following two requirements:

- the service, procedure, or treatment must otherwise be a covered service under the Certificate; and
- in general, you must have received a final adverse determination through the first level of our internal Appeal process. But, you can file an external Appeal even though you have not received a final adverse determination through the first level of our internal Appeal process if:
  - we agree in writing to waive the internal Appeal. We are not required to agree to your request to waive the internal Appeal; or
  - you file an external Appeal at the same time as you apply for an expedited internal Appeal; or
  - we fail to adhere to utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and we demonstrate that the violation was for good cause or due to matters beyond our control and the violation occurred during an ongoing, good faith exchange of information between you and us).

II. Your Right to Appeal a Determination That a Service Is Not Medically Necessary

If we have denied coverage on the basis that the service does not meet our requirements for Medical Necessity, you may Appeal to an External Appeal Agent if you meet the requirements for an external Appeal in I. above.

III. Your Right to Appeal a Determination That a Service Is Experimental or Investigational

If we have denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the two requirements for an external Appeal in I. above and your attending Physician must certify that: (1) your condition or disease is one for which standard health services are ineffective or medically inappropriate; or (2) one for which there does not exist a more beneficial standard service or procedure covered by us; or (3) one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending Physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending Physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be your treating Physician.

IV. Your Right to Appeal a Determination That a Service Is Out-of-Network

If we have denied coverage of an Out-of-Network treatment because it is not materially different than the health service available In-Network, you may Appeal to an External Appeal Agent if you meet the two requirements for an external Appeal in I. above, and you have requested preauthorization for the Out-of-Network treatment.

In addition, your attending Physician must certify that the Out-of-Network service is materially different from the alternate recommended In-Network health service, and based on two documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-
Network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate In-Network health service.

For purposes of this section, your attending Physician must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area appropriate to treat you for the health service.

You do not have a right to an external Appeal for a denial of a referral to an Out-of-Network provider on the basis that a health care provider is available In-Network to provide the particular health service requested by you.

V. The External Appeal Process

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external Appeal. If you are filing an external Appeal based on our failure to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external Appeal.

We will provide an external Appeal application with the final adverse determination issued through the first level of our internal Appeal process or our written waiver of an internal Appeal. You may also request an external Appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you meet the criteria for an external Appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with your external Appeal request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which we based our denial, the External Appeal Agent will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm our decision. Please note that in the case of an expedited Appeal (described below), we do not have a right to reconsider our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your Physician, or us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

If your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending Physician certifies that the standard external Appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external Appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and us by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment we will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Certificate for non-experimental or non-investigational treatments provided in the clinical trial.

The External Appeal Agent’s decision is binding on both you and us. The External Appeal Agent’s decision is admissible in any court proceeding.

We will charge you a fee of $25 for each external Appeal, not to exceed $75 in a single plan year. The external Appeal application will explain how to submit the fee. We will waive the fee if we determine that paying the fee would be a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to you.

VI. Your Responsibilities

It is your RESPONSIBILITY to start the external Appeal process. You may start the external Appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

Under New York State law, your completed request for external Appeal must be filed within four (4) months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal Appeal, or our failure to adhere to claim processing requirements. We have no authority to extend this deadline.
**Notice of Benefit Determination on Grievance or Appeal**

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

In addition, every notice of a utilization review final adverse determination must include: a clear statement describing the basis and clinical rationale for the denial as applicable to the insured; a clear statement that the notice constitutes the final adverse determination; Cigna’s contact person and his or her telephone number; the insured's coverage type; the name and full address of Cigna's utilization review agent, if any; the utilization review agent’s contact person and his or her telephone number; a description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or Physician proposed to provide the treatment and the developer/manufacturer of the health care service; a statement that the insured may be eligible for an external Appeal and the time frames for requesting an Appeal; and a clear statement written in bolded text that the 45-day time frame for requesting an external Appeal begins upon receipt of the final adverse determination of the first level Appeal, regardless of whether or not a second level Appeal is requested, and that by choosing the request a second level internal Appeal, the time may expire for the insured to request an external Appeal.

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

**Relevant Information**

Relevant Information is any document, record, or other information which: was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit 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 Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

**Certificate Rider**

Policyholder: Pace University
Rider Eligibility: Each Employee
Policy No. or Nos. 3331784-CN5
Effective Date: July 1, 2015
You will become insured on the date you become eligible 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. If you are not insured for the benefits described in your certificate on that date, the effective date of this certificate rider will be the date you become insured.
This certificate rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified above.

Anna Krish Baldwin, Corporate Secretary

The following text is added to the first sub-section of the Family Planning Services section of the certificate Schedule:

Note:
The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs)). Diaphragms will also be covered when services are provided in the physician’s office.

The Covered Expenses section of the certificate is amended, as follows:

The “charges made for Family Planning, including medical history…” sub-item is changed to read:

- 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).

The following text is added to the Covered Expenses provision of the Prescription Drug Benefits section of the certificate:

The term “Covered Expenses” also includes contraceptive drugs, and prescription appliances for contraception, except if prescribed for reasons other than contraceptive purposes.

The following text is deleted from the Exclusions and Limitations of Coverage section of the certificate:

The following text is deleted from the Exclusions provision of the Prescription Drug Benefits section of the certificate:

- implantable contraceptive products;

- contraceptive drugs, and prescription appliances for contraception, except if prescribed for reasons other than contraceptive purposes;

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.

- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

Bed and Board

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

Charges

The term "charges" means the actual billed charges. It also means an amount negotiated by a provider, billed directly or indirectly, with Cigna if that amount is different from the actual billed charges.
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.

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 which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

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

The term spouse also includes your same-sex partner in your marriage that was legally performed in another jurisdiction.

The term child means a child born to you or a child legally adopted by you from the start of any waiting period prior to the finalization of the child's adoption. It also includes a newborn infant who is adopted by you from the moment you take physical custody of the child upon the child's release from the hospital prior to the finalization of the child's adoption. It also includes a stepchild, a foster child, 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 year in which the limiting age is reached.

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

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

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence, as demonstrated by a driver’s license, tax return or other sufficient proof;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements:
  - a joint bank account;
  - a joint credit card or charge card;
  - joint obligation on a loan;
  - status as an authorized signatory on the partner's bank account, credit card or charge card;
  - joint ownership of holdings or investments;
  - joint ownership of residence;
  - joint ownership of real estate other than residence;
  - listing of both partners as tenants on the lease of the shared residence;
  - shared rental payments of residence (this need not be shared 50/50);
  - listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
  - a common household and shared household expenses, e.g. grocery bills, utility bills, telephone bills, etc. (this need not be shared 50/50);
  - shared household budget for purposes of receiving government benefits;
  - status of one as representative payee for the other’s government benefits;
  - joint ownership of major items of personal property, e.g. appliances, furniture;
  - joint ownership of a motor vehicle;
  - joint responsibility for child care, e.g. school documents, guardianship;
  - shared child-care expenses, e.g. babysitting, day care, school bills (this need not be shared 50/50);
  - execution of wills naming each other as executor and/or beneficiary;
• designation as beneficiary under the other’s life insurance policy;
• designation as beneficiary under the other’s retirement benefits account;
• mutual grant of durable power of attorney;
• mutual grant of authority to make health care decisions, e.g. health care power of attorney;
• affidavit by creditor or other individual able to testify to partners’ financial interdependence; or
• such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;
• is not a blood relative any closer than would prohibit legal marriage; and
• has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:
• has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
• is currently legally married to another person; or
• has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

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

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

Emergency Medical Condition
The term Emergency medical condition means a medical condition or behavioral condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such as 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 person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
• serious impairment to such person’s bodily functions;
• serious dysfunction of any bodily organ or part of such person; or
• serious disfigurement of such person.

Emergency Services
Emergency services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Employee
The term Employee means a full-time 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 28 hours a week for the Employer.

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

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

Free-Standing Surgical Facility
The term Free-standing Surgical Facility means an institution which meets all of the following requirements:
- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

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

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

Hospital
The term Hospital means:
- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance Abuse or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

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

Injury
The term Injury means an accidental bodily injury.

Maintenance Treatment
The term Maintenance Treatment means:
- treatment rendered to keep or maintain the patient's current status.

Maximum Reimbursable Charge - Medical
The Maximum Reimbursable Charge for covered services is determined based on the lesser of:
- the provider’s normal charge for a similar service or supply; or
- a policyholder-selected percentage of a schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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

In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:
- the provider’s normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

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

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.

Medically Necessary/Medical Necessity
Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:
- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining the least intensive setting.
Medicare
The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

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

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

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."

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

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

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

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

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

Physician
The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

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

Prescription Drug List
Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

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

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

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

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.

Related Supplies
Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes...
for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

**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.

**Sickness – For Medical Insurance**

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

**Skilled Nursing Facility**

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:
- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis; but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

**Specialist**

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

**Stabilize**

Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

**Terminal Illness**

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

**Urgent Care**

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.