University of Maine System

OPEN ACCESS PLUS MEDICAL BENEFITS
UMS Quality Incentive & PAFTA Copay Plan

EFFECTIVE DATE: January 1, 2023

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This document printed in April, 2023 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
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Important Information

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

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

The Policy is guaranteed renewable for periods of one year, with limited exceptions (specifically, the Policyholder’s failure to pay premium; fraud or intentional misrepresentation of material fact by the Policyholder or by you or your representative; failure of the employee group to have the number of employees purchasing the insurance coverage that Cigna requires in order to provide coverage; or when, if ever, Cigna decides to no longer offer insurance coverage at all or the specific type of insurance provided for in this certificate).
Explanation of Terms
You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule
The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.
Special Plan Provisions
When you select a Participating Provider, this plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

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

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

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.

Important Information
Rebates and Other Payments
Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals covered under your plan and Prescription Drug Products included on the Prescription Drug List. These rebates or remuneration are not obtained on your behalf or for your benefit. Cigna, its affiliates and the plan are not obligated to pass these rebates on to you, or apply them to your plan’s Deductible if any or take them into account in determining your Copayments and/or Coinsurance.

Cigna and its affiliates or designees, conduct business with various pharmaceutical manufacturers separate and apart from this plan’s Medical Pharmaceutical and Prescription Drug Product benefits. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this plan.
Cigna and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.

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

Discrimination is Against the Law
Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.
Cigna:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as

- Qualified interpreters
- Information written in other languages

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

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

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

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

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf


Proficiency of Language Assistance Services

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

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

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

**Vietnamese** – XIN LUU Y: Quy vi duoc cap dich vu tro giup ve ngon ngu mien phi. Dang cho khach hang lien tay cua Cigna, vui long goi so o mat sau the Hoi vien. Các trường hop khac xin goi so 1.800.244.6224 (TTY: Quay so 711).

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


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

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

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

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

**Polish** – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).
Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

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


Persian (Farsi) – توجه: خدمات کمک زبانی به صورت رایگان به شما ارائه می‌شود. برای مشورت فعال Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 (شماره بگیرید (شماره تلفن ویژه ناشنوایان: شماره1171ر با شماره‌گیری کدی).

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

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

Non-Quantitative Treatment Limitations (NQTLs) include:

- Exclusions and/or restrictions based on geographic location, facility type or provider specialty.
- A description of your plan’s NQTL methodologies and processes applied to medical/surgical benefits and MH/SUD benefits is available for review by Plan Administrators (e.g. employers) and covered persons by accessing the appropriate link below:
  - Covered Persons: www.cigna.com/sp

To determine which document applies to your plan, select the relevant health plan product; medical management model (inpatient only or inpatient and outpatient) which can be located in this booklet immediately following The Schedule; and pharmacy coverage (whether or not your plan includes pharmacy coverage).

Important Notice Regarding Cancellation of Coverage

This notice is to advise you that you have the right to designate a third party to receive notice of cancellation of your coverage under this plan.

Designation of Third Party to Receive Notice

If you would like to designate a third party to receive notice of cancellation of your coverage, you can call Customer Service at 1-800-244-6224 or the phone number shown on your ID card. Customer Service will send to you a “Third Party Notice Request Form,” which you should complete and return to your Employer or Plan Administrator, as appropriate.

You also have the right to change the person or party you have designated to receive notice of cancellation of your coverage. A request to change designation should be made in writing to your Employer or Third Party Administrator.

Right to Reinstatement for Insureds with Organic Brain Disease

Should your coverage be cancelled, you have the right to have your coverage reinstated if:

- you suffer from an organic brain disease; and
- the reason your coverage cancelled was because you did not pay your premium or because of another lapse or default on your part.

“Organic brain disease” means a mental or nervous disorder with a demonstrable organic origin, causing significant cognitive impairment, including, but not limited to:

- Pick’s Disease;

myCigna.com
Important Notice Regarding Prescription Drug Coverage

If you have been undergoing a course of treatment with a prescription drug by prior authorization of a carrier, and your coverage with that carrier is replaced with coverage by Cigna Health and Life Insurance Company (Cigna), Cigna has the right to request a review with your prescribing provider.

Cigna will honor the previous carrier’s prior authorization for that prescription drug for a period not to exceed six months, if your provider participates in the review and requests that the prior authorization be continued.

The prescription must be for a condition or service that is covered by Cigna. Coverage is subject to the copayments and/or coinsurance requirements of the Cigna plan.

Cigna Physician Designations

PLEASE NOTE: Provider performance ratings should only be used as a guide for choosing a provider. You should consult your current provider before making a decision about your health care based on a provider rating.

Our goal is to provide you with helpful information and access to affordable health services. One way we do this is by collecting and comparing claim and other information. With it, we can assess the quality and cost of care delivered by primary care doctors and specialists.

We identify doctors meeting health industry standards, such as board certification or completion of quality programs. Other information shows how individual doctors treat specific health conditions and how that treatment compares with national medical standards and care delivered by similar, local doctors.

Primary care doctors and specialists who meet defined measures and criteria receive our Physician Quality and Cost Efficiency Designation. Doctors who practice one of 21 specialties, live in specific parts of the country, and also meet cost and quality criteria, may receive our Cigna Care Designation.

We don’t change the way we pay doctors based on these designations. We developed them to help you choose the doctors who best meet your needs. We encourage you to consider this information but please consult other sources as well, including doctors who are treating you.

This is important because we base our assessments only on information we can collect, so we don’t have a complete picture of a doctor’s practice. In some cases, we don’t have enough information for an assessment and there is some room for error in all data analysis.

How To File Your Claim

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

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

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.

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

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

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

Timely Filing of Out-of-Network Claims

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

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.
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 as determined by your Employer; and
- you are an eligible full-time or part-time Employee as determined by your Employer; 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
Date of hire.

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

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

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

Late Entrant - Employee
You are a Late Entrant if:
- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

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

Effective Date of Dependent Insurance
Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the date 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 you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

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.
# Open Access Plus Medical Benefits
## The Schedule

### For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care on 3 levels: UMS Preferred (Tier A), Cigna In-Network (Tier B) and Cigna Out-of-Network Tier C. Tier A benefits are managed and coordinated by University of Maine System. 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.

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

If you are unable to locate a Tier A or Tier B 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 Covered Expenses that an insured person is required to pay under the plan in addition to the Deductible, if any.

### Copayments/Deductibles

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

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

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

### 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.

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

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

- Non-compliance penalties.
- Any copayments and/or benefit deductibles.
- Provider charges in excess of the Maximum Reimbursable Charge.
Open Access Plus Medical Benefits
The Schedule

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

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

Assistant Surgeon and Co-Surgeon Charges

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

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

Out-of-Network Charges for Certain Services
Charges for services furnished by an Out-of-Network provider in an In-Network facility while you are receiving In-Network services at that In-Network facility: (i) are payable at the In-Network cost-sharing level; and (ii) the allowable amount used to determine the Plan's benefit payment is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-Participating (Out-of-Network) provider.

2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.

3. The allowable amount used to determine the Plan’s benefit payment when Out-of-Network Emergency Services result in an inpatient admission is the median amount negotiated with In-Network facilities.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>UMS Preferred</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td></td>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

myCigna.com
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
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<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Percentage of Covered Expenses the Plan Pays</td>
<td>100%</td>
<td>100%</td>
<td>80% of the Maximum Reimbursable Charge</td>
</tr>
</tbody>
</table>

**Note:**
"No charge" means an insured person is not required to pay Coinsurance.
### Maximum Reimbursable Charge

The Maximum Reimbursable Charge for Out-of-Network services other than those described in the Schedule sections Out-of-Network Charges for Certain Services and Out-of-Network Emergency Services Charges is determined based on the lesser of the provider's normal charge for a similar service or supply; or the amount agreed to by the Out-of-Network provider and Cigna, or a policyholder-selected percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable reimbursement for the same or similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider’s normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.

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

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
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<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Reimbursable Charge</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>200%</td>
</tr>
</tbody>
</table>
**BENEFIT HIGHLIGHTS**

<table>
<thead>
<tr>
<th>Note:</th>
<th>UMS Preferred</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some providers forgive or waive the cost share obligation (e.g. your deductible and/or coinsurance) that this plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this plan. For more details, see the Exclusions Section.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Calendar Year Deductible**

<table>
<thead>
<tr>
<th>Individual</th>
<th>UMS Preferred</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250 per person</td>
<td>$250 per person</td>
<td>$250 per person</td>
<td></td>
</tr>
<tr>
<td>$500 per family</td>
<td>$500 per family</td>
<td>$500 per family</td>
<td></td>
</tr>
</tbody>
</table>

**Individual Calculation:**

Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.

**Out-of-Pocket Maximum**

<table>
<thead>
<tr>
<th>Individual</th>
<th>UMS Preferred</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,500 per person</td>
<td>$1,500 per person</td>
<td>$2,500 per person</td>
<td></td>
</tr>
<tr>
<td>$3,000 per family</td>
<td>$3,000 per family</td>
<td>$5,000 per family</td>
<td></td>
</tr>
</tbody>
</table>

**Individual Calculation:**

Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>UMS Preferred</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Physician’s Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>No charge after $15 per office visit copay</td>
<td>No charge after $15 per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Surgery Performed in the Physician’s Office</td>
<td>No charge after the $15 PCP per office visit copay</td>
<td>No charge after the $15 PCP per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Second Opinion Consultations (provided on a voluntary basis)</td>
<td>No charge after the $15 PCP per office visit copay</td>
<td>No charge after the $15 PCP per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Allergy Treatment/Injections</td>
<td>No charge after either the $15 PCP per office visit copay or the actual charge, whichever is less</td>
<td>No charge after either the $15 PCP per office visit copay or the actual charge, whichever is less</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Allergy Serum (dispensed by the Physician in the office)</td>
<td>No charge</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Care Physician Services</strong></td>
<td></td>
<td></td>
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<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>
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</tr>
<tr>
<td>Office Visits</td>
<td>No charge after the $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Consultant and Referral Physician’s Services</td>
<td>No charge after the $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Surgery Performed by a Specialist in the Physician’s Office</td>
<td>No charge after the $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Second Opinion Consultations performed by a Specialist (provided on a voluntary basis)</td>
<td>No charge after the $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Allergy Treatment/Injections performed by a Specialist</td>
<td>No charge after the $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Allergy Serum (dispensed by the Specialist in the office)</td>
<td>No charge</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td><strong>Convenience Care Clinic</strong> (includes any related lab and x-ray services and surgery)</td>
<td>No charge after the $15 per office visit copay</td>
<td>No charge after the $15 per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
</tbody>
</table>
### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Virtual Care</th>
<th>UMS Preferred</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated Virtual Providers</td>
<td>Dedicated virtual care services may be provided by MDLIVE, a Cigna affiliate. Services available through contracted virtual providers as medically appropriate.</td>
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<tr>
<td>Notes:</td>
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<tr>
<td>• Primary Care cost share applies to routine care. Virtual wellness screenings are payable under preventive care.</td>
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<tr>
<td>• MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below).</td>
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<tr>
<td>• Lab services supporting a virtual visit must be obtained through dedicated labs.</td>
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<tr>
<td>MDLIVE Urgent Care Services</td>
<td>No charge</td>
<td>No charge</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>MDLIVE Primary Care Services</td>
<td>No charge after the $15 per visit copay</td>
<td>No charge after the $15 per visit copay</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>MDLIVE Specialty Care Services</td>
<td>No charge after the $40 per visit copay</td>
<td>No charge after the $40 per visit copay</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Virtual Physician Services</td>
<td></td>
<td></td>
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<tr>
<td>Services available through Physicians as medically appropriate.</td>
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<tr>
<td>Note: Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).</td>
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</tr>
<tr>
<td>Physician Virtual Office Visit</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>UMS Preferred</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>-----------------------------------------</td>
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<tr>
<td>Preventive Care</td>
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<tr>
<td><strong>Note:</strong></td>
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</tr>
<tr>
<td>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Routine Preventive Care - all ages</td>
<td>No charge</td>
<td>No charge</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Immunizations - all ages</td>
<td>No charge</td>
<td>No charge</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td></td>
<td>Also includes sports physicals and immunizations for travel.</td>
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<tr>
<td>Early Intervention Services</td>
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<tr>
<td><strong>Note:</strong> Benefits are provided for early intervention services for members ages birth to 36 months of age with an identified developmental disability or delay.</td>
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</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Mammograms, PSA, PAP Smear</td>
<td></td>
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<tr>
<td>Preventive Care Related Services (i.e. “routine” services)</td>
<td>No charge</td>
<td>No charge</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Diagnostic Related Services (i.e. “non-routine” services)</td>
<td>Subject to the plan’s x-ray &amp; lab benefit; based on place of service</td>
<td>Subject to the plan’s x-ray &amp; lab benefit; based on place of service</td>
<td>Subject to the plan’s x-ray &amp; lab benefit; based on place of service</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
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<td>OUT-OF-NETWORK</td>
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<tr>
<td><strong>Inpatient Hospital – Facility Services</strong></td>
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</tr>
<tr>
<td>Semi-Private Room and Board</td>
<td>Limited to the semi-private room negotiated rate</td>
<td>Limited to the semi-private room negotiated rate</td>
<td>Limited to the semi-private room rate</td>
</tr>
<tr>
<td>Private Room</td>
<td>Limited to the semi-private room negotiated rate</td>
<td>Limited to the semi-private room negotiated rate</td>
<td>Limited to the semi-private room rate</td>
</tr>
<tr>
<td>Special Care Units (ICU/CCU)</td>
<td>Limited to the negotiated rate</td>
<td>Limited to the negotiated rate</td>
<td>Limited to the ICU/CCU daily room rate</td>
</tr>
<tr>
<td><strong>Outpatient Facility Services</strong></td>
<td></td>
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</tr>
<tr>
<td>Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room</td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td><strong>Note:</strong> Non-surgical treatment procedures are not subject to the facility copay or facility deductible.</td>
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</tr>
<tr>
<td><strong>Inpatient Hospital Physician’s Visits/Consultations</strong></td>
<td>100% (PCP), 100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>100% (PCP), 100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Professional Services</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Surgeon</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Radiologist</td>
<td>100% after plan deductible</td>
<td>100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Pathologist</td>
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<tr>
<td>Anesthesiologist</td>
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<tr>
<td><strong>Outpatient Professional Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Radiologist</td>
<td>100% after plan deductible</td>
<td>100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Pathologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
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<tr>
<td><strong>Urgent Care Services</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</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>
<td>No charge after $25 per visit copay*</td>
</tr>
<tr>
<td>*waived if admitted</td>
<td>*waived if admitted</td>
<td>*waived if admitted</td>
<td>*waived if admitted</td>
</tr>
<tr>
<td>Outpatient Professional Services (radiology, pathology, physician)</td>
<td>No charge after plan deductible</td>
<td>No charge after plan deductible</td>
<td>No charge after plan deductible</td>
</tr>
<tr>
<td>X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit)</td>
<td>No charge after plan deductible</td>
<td>No charge after plan deductible</td>
<td>No charge after plan deductible</td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)</td>
<td>No charge after $50 scan copay and plan deductible</td>
<td>No charge after $50 scan copay and plan deductible</td>
<td>No charge after $50 scan copay and plan deductible</td>
</tr>
<tr>
<td>The scan copay/deductible applies per type of scan per day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>No charge after $100 per visit copay*</td>
<td>No charge after $100 per visit copay*</td>
<td>No charge after $100 per visit copay*</td>
</tr>
<tr>
<td>*waived if admitted</td>
<td>*waived if admitted</td>
<td>*waived if admitted</td>
<td>*waived if admitted</td>
</tr>
<tr>
<td>Outpatient Professional Services (radiology, pathology, ER physician)</td>
<td>No charge after plan deductible</td>
<td>No charge after plan deductible</td>
<td>No charge after plan deductible</td>
</tr>
<tr>
<td>X-ray and/or Lab performed at the Emergency Room Facility (billed by the facility as part of the ER visit)</td>
<td>No charge after plan deductible</td>
<td>No charge after plan deductible</td>
<td>No charge after plan deductible</td>
</tr>
<tr>
<td>Independent X-ray and/or Lab Facility in conjunction with an ER visit</td>
<td>No charge after plan deductible</td>
<td>No charge after plan deductible</td>
<td>No charge after plan deductible</td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)</td>
<td>No charge after $50 scan copay and plan deductible</td>
<td>No charge after $50 scan copay and plan deductible</td>
<td>No charge after $50 scan copay and plan deductible</td>
</tr>
<tr>
<td>The scan copay/deductible applies per type of scan per day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Air Ambulance</strong></td>
<td>100% after plan deductible</td>
<td>100% after plan deductible</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>100% after plan deductible</td>
<td>100% after plan deductible</td>
<td>100% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>UMS Preferred</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------</td>
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</tr>
<tr>
<td><strong>Inpatient Services at Other Health Care Facilities</strong>&lt;br&gt;Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities&lt;br&gt;Calendar Year Maximum: 100 days combined</td>
<td>100% after plan deductible</td>
<td>100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td><strong>Laboratory and Radiology Services (includes pre-admission testing)</strong>&lt;br&gt;Physician’s Office Visit</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Outpatient Hospital Facility</td>
<td>100% after plan deductible</td>
<td>100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Independent X-ray and/or Lab Facility</td>
<td>100% after plan deductible</td>
<td>100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td><strong>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</strong>&lt;br&gt;The scan copay/deductible applies per type of scan per day</td>
<td>No charge after $50 scan copay</td>
<td>No charge after $50 scan copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td></td>
<td></td>
<td>$200 per admission deductible, then 100% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>$50 scan copay, then 100% after plan deductible</td>
<td>$50 scan copay, then 100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>UMS Preferred</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>----------------------------------------</td>
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<td>----------------------------------------------------</td>
</tr>
<tr>
<td>Outpatient Therapy Services and</td>
<td>No charge after the $15 per</td>
<td>No charge after the $15 per</td>
<td>80% of the Maximum Reimbursable Charge after plan</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>office visit copay</td>
<td>office visit copay</td>
<td>deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
<td></td>
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<tr>
<td>Cardiac Rehab</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary Rehab</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cognitive Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Therapy (includes</td>
<td></td>
<td></td>
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<tr>
<td>Chiropractors)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massage Therapy is covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>when part of a chiropractic visit.</td>
<td></td>
<td></td>
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<tr>
<td>Includes speech, physical, and/or</td>
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<tr>
<td>occupational therapy for the treatment</td>
<td></td>
<td></td>
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<tr>
<td>of Autism Spectrum Disorder.</td>
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</tr>
<tr>
<td>Acupuncture</td>
<td>No charge after $15 copay</td>
<td>No charge after $15 copay</td>
<td>80% of the Maximum Reimbursable Charge after plan</td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
<td></td>
<td>deductible</td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture is covered</td>
<td></td>
<td></td>
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<tr>
<td>regardless of diagnosis.</td>
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<td></td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>100% after plan deductible</td>
<td>100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan</td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
<td></td>
<td>deductible</td>
</tr>
<tr>
<td>(includes outpatient private nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>when approved as Medically Necessary)</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>100% after plan deductible</td>
<td>100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan</td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td></td>
<td></td>
<td>deductible</td>
</tr>
<tr>
<td>Includes respite services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>100% after plan deductible</td>
<td>100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan</td>
</tr>
<tr>
<td>(same coinsurance level as Home Health</td>
<td></td>
<td></td>
<td>deductible</td>
</tr>
<tr>
<td>Care Services)</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>UMS Preferred</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>-----------------------------------------</td>
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<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Bereavement Counseling</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services provided as part of Hospice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>100% after plan deductible</td>
<td>100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% after plan deductible</td>
<td>100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Services provided by Mental Health</td>
<td>Covered under Mental Health</td>
<td>Covered under Mental Health benefit</td>
<td>Covered under Mental Health benefit</td>
</tr>
<tr>
<td>Professional</td>
<td>benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gene Therapy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes prior authorized gene therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>products and services directly related</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to their administration, when</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically Necessary.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gene therapy must be received at an</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network facility specifically</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>contracted with Cigna to provide the</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>specific gene therapy. Gene therapy at</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>other In-Network facilities is not</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>covered.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gene Therapy Product</td>
<td>Not applicable</td>
<td>Subject to In-Network facility cost share</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>based on place of service; separate from</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>facility charges</td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Not applicable</td>
<td>$200 per admission copay, then 100%</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>after plan deductible</td>
<td></td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Not applicable</td>
<td>$100 per visit copay, then 100%</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>after plan deductible</td>
<td></td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>Not applicable</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>plan deductible</td>
<td></td>
</tr>
<tr>
<td>Travel Maximum: $10,000 per episode of</td>
<td>Not applicable</td>
<td>No charge (available only for travel</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>gene therapy</td>
<td></td>
<td>when prior authorized to receive gene</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>therapy at a participating In-Network</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>facility specifically contracted with</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cigna to provide the specific gene</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>therapy)</td>
<td></td>
</tr>
</tbody>
</table>
## BENEFIT HIGHLIGHTS

### Maternity Care Services

<table>
<thead>
<tr>
<th></th>
<th>UMS Preferred</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Initial Visit to Confirm Pregnancy</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
</tbody>
</table>

**Note:**
OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.

All subsequent Prenatal Visits, Postnatal Visits and Physician’s Delivery Charges (i.e. global maternity fee)

Physician’s Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist

Delivery - Facility (Inpatient Hospital, Birthing Center)

$200 per admission copay, then 100% after plan deductible

**Abortion**

Includes elective and non-elective procedures

Physician’s Office Visit

No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay

Inpatient Facility

$200 per admission copay, then 100% after plan deductible

Outpatient Facility

$100 per visit copay, then 100% after plan deductible

Physician’s Services

100% (Tier 1) or 100% (non-Tier 1) after plan deductible

Inpatient Facility (Inpatient Hospital, Birthing Center)

$200 per admission copay, then 100% after plan deductible

$200 per admission deductible, then 80% of the Maximum Reimbursable Charge after plan deductible

Outpatient Facility

$100 per visit deductible, then 80% of the Maximum Reimbursable Charge after plan deductible

100% (Tier 1) or 100% (non-Tier 1) after plan deductible

80% of the Maximum Reimbursable Charge after plan deductible
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>UMS Preferred</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women’s Family Planning Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits, Lab and Radiology Tests and Counseling</td>
<td>No charge</td>
<td>No charge</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician’s office. Surgical Sterilization Procedures for Tubal Ligation (includes reversals)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge</td>
<td>No charge</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge</td>
<td>No charge</td>
<td>$200 per admission deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No charge</td>
<td>No charge</td>
<td>$100 per visit deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>No charge</td>
<td>No charge</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>UMS Preferred</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
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<td>------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Men's Family Planning Services</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Office Visits, Lab and Radiology Tests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Sterilization Procedures</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>for Vasectomy (includes reversals)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility Services</td>
<td>Note: Coverage will be provided for only certain infertility services. Please see the Infertility Services section for the description of covered infertility services, as well as excluded infertility services. Covered surgical treatment is limited to procedures for the correction of infertility, and excludes In-vitro, GIFT, ZIFT, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit (Lab and</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Radiology Tests, Counseling) to</td>
<td></td>
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</tr>
<tr>
<td>diagnose the infertility condition</td>
<td></td>
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</tr>
<tr>
<td>Inpatient Facility</td>
<td>$100 per admission copay, then 50% after plan deductible</td>
<td>$200 per admission copay, then 50% after plan deductible</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>All covered services billed by an</td>
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<tr>
<td>inpatient facility to treat the</td>
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<tr>
<td>infertility condition</td>
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</tr>
<tr>
<td>Outpatient Facility</td>
<td>$100 per visit copay, then 50% after plan deductible</td>
<td>$100 per visit copay, then 50% after plan deductible</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>All covered services billed by an</td>
<td></td>
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</tr>
<tr>
<td>outpatient facility to treat the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>infertility condition</td>
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<td></td>
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</tr>
<tr>
<td>Physician’s Services</td>
<td>50% (Tier 1) or 50% (non-Tier 1) after plan deductible</td>
<td>50% (Tier 1) or 50% (non-Tier 1) after plan deductible</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>All covered services billed by a</td>
<td></td>
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<tr>
<td>Physician to treat the infertility</td>
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<td></td>
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<tr>
<td>condition</td>
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</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>UMS Preferred</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
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<tr>
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</tr>
<tr>
<td>Transplant Services and Related Specialty Care</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100% at LifeSOURCE center after plan deductible, otherwise 100% after $200 per admission copay and plan deductible</td>
<td>100% at LifeSOURCE center after plan deductible, otherwise 100% after $200 per admission copay and plan deductible</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100% at LifeSOURCE center, otherwise 100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>100% at LifeSOURCE center, otherwise 100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Lifetime Travel Maximum: $10,000 per transplant</td>
<td>No charge (only available when using LifeSOURCE facility)</td>
<td>No charge (only available when using LifeSOURCE facility)</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>No charge</td>
<td>100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td>No charge</td>
<td>100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Note: Must use a Cigna Vendor to receive In-Network benefits.</td>
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</tr>
<tr>
<td>Outpatient Dialysis Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician's Office Visit</td>
<td>Not applicable</td>
<td>No charge after the $15 PCP or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Not applicable</td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Physician's Services</td>
<td>Not applicable</td>
<td>100% (non-Tier 1) after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Home Setting</td>
<td>Not applicable</td>
<td>100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>UMS Preferred</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
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<td>----------------------------------------------------</td>
</tr>
<tr>
<td><strong>Breast Feeding Equipment and Supplies</strong></td>
<td>No charge</td>
<td>No charge</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td><strong>Note:</strong> Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.</td>
<td></td>
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</tr>
<tr>
<td><strong>External Prosthetic Appliances</strong></td>
<td>$100 EPA deductible per Calendar Year, then 100% after plan deductible</td>
<td>$100 EPA deductible per Calendar Year, then 100% after plan deductible</td>
<td>$100 EPA deductible per Calendar Year, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
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</tr>
<tr>
<td><strong>Note:</strong> Must use a Cigna Vendor to receive In-Network benefits.</td>
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<tr>
<td>Includes:</td>
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<tr>
<td>• Orthotics.</td>
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<tr>
<td>• Knee-shin system endoskeletal single axis fluid swing and stance phase control.</td>
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<tr>
<td>• Knee-shin system adjustable stance flexion feature.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Knee-shin system fluid stance extension dampening feature.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Electronic knee-shin system swing and stance phase.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Endoskeletal ankle foot system.</td>
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<td></td>
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</tr>
<tr>
<td><strong>Nutritional Counseling</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of mental health and substance use disorder conditions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physician’s Office Visit</strong></td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td><strong>Inpatient Facility</strong></td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td><strong>Outpatient Facility</strong></td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td><strong>Physician’s Services</strong></td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
</tbody>
</table>
## BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Service</th>
<th>UMS Preferred</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Genetic Counseling</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Calendar Year Maximum: 3 visits per person for Genetic Counseling for both pre- and post-geneic testing; however, the 3 visit limit will not apply to Mental Health and Substance Use Disorder conditions.</td>
<td>Not applicable</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Inpatient Facility</td>
<td></td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td></td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td></td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
</tbody>
</table>

**Dental Care**

Limited to charges made for a continuous course of dental treatment started within six months of an injury to teeth.

<table>
<thead>
<tr>
<th>Service</th>
<th>UMS Preferred</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office Visit</td>
<td></td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>UMS Preferred</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
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<td>--------------------------------</td>
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</tr>
<tr>
<td><strong>Consumable Medical Supplies</strong></td>
<td>100% after plan deductible</td>
<td>100% after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
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</tr>
<tr>
<td><strong>Note:</strong> Includes coverage for Compression Stockings. Must be Cigna Vendor to receive In-Network benefits.</td>
<td></td>
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</tr>
</tbody>
</table>

| **Eye Care Services** | Not applicable | No charge | No charge |
| Maximaums: |               |            |            |
| • One eye exam every 12 months up to age 18; |               |            |            |
| • One eye exam every 24 months for 18 years and over. |               |            |            |
| **Note:** Includes coverage for routine vision exams. |               |            |            |

| **Hearing Aids** | 100% after plan deductible | 100% after plan deductible | 80% of the Maximum Reimbursable Charge after plan deductible |
| Maximum: 2 devices (one per ear) per 36 months |               |            |                |
| **Note:** Includes testing and fitting of hearing aid devices at Physician’s Office Visit cost share. |               |            |                |

| **Hearing Services** | No charge | No charge | 80% of the Maximum Reimbursable Charge after plan deductible |
| Calendar Year Maximum: Unlimited |               |            |                |
| **Note:** Includes coverage for hearing exam only. |               |            |                |

| **Wigs** | 100% after plan deductible | 100% after plan deductible | 80% of the Maximum Reimbursable Charge after plan deductible |
| Lifetime Maximum: Unlimited |               |            |                |

<p>| <strong>Dental Varnish</strong> | 100% | 100% | 100% |
| Calendar Year Maximum: Unlimited |               |            |                |</p>
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>UMS Preferred</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oral Surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
</tbody>
</table>

**Note:** Includes removing impacted or unerupted teeth in a non-hospital or non-rural health center setting; removing seven or more permanent teeth; Gingivectomies; Osseous surgery; setting of jaw fracture, removal of tumor or cyst; dental services needed as a result of chemotherapy; repairing or replacing dental prostheses due to accidental injury.
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>UMS Preferred</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity/Bariatric Surgery</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>No charge after the $15 PCP or applicable $35 Tier 1 or $40 non-Tier 1 Specialist per office visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Note: Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the “Exclusions, Expenses Not Covered and General Limitations” section of this certificate.</td>
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</tr>
<tr>
<td>Physician’s Office Visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit copay, then 100% after plan deductible</td>
<td>$100 per visit deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>100% (Tier 1) or 100% (non-Tier 1) after plan deductible</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td>Surgical Professional Services</td>
<td></td>
<td></td>
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<tr>
<td>Lifetime Maximum: Unlimited</td>
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<tr>
<td>Notes:</td>
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<tr>
<td>• Includes charges for surgeon only; does not include radiologist, anesthesiologist, etc.</td>
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<tr>
<td>• Does not accumulate to the Out-of-Pocket Maximum.</td>
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</tr>
<tr>
<td>• Only surgical services accumulate to the maximum.</td>
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<td></td>
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</tr>
<tr>
<td>Routine Foot Disorders</td>
<td>Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary</td>
<td>Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.</td>
<td>Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.</td>
</tr>
<tr>
<td>Treatment Resulting From Life Threatening Emergencies</td>
<td>Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.</td>
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</tr>
</tbody>
</table>
### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th></th>
<th>UMS Preferred</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>$100 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td></td>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>$15 per visit copay</td>
<td>$15 per visit copay</td>
<td>$80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td></td>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
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</tr>
<tr>
<td><strong>Dedicated Virtual Providers</strong> MDLIVE Behavioral Services</td>
<td>No charge after the $15 per visit copay</td>
<td>No charge after the $15 per visit copay</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td><strong>Outpatient - All Other Services</strong> Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc.</td>
<td>100%</td>
<td>100%</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td></td>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
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</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>UMS Preferred</td>
<td>IN-NETWORK</td>
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</tr>
<tr>
<td><strong>Substance Use Disorder</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>$100 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission copay, then 100% after plan deductible</td>
<td>$200 per admission deductible, then 80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td></td>
<td>(Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment)</td>
<td>(Calendar Year Maximum: Unlimited)</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>$15 per visit copay</td>
<td>$15 per visit copay</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td></td>
<td>(Includes individual, family and group psychotherapy; medication management, virtual care, etc.)</td>
<td>(Calendar Year Maximum: Unlimited)</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td></td>
<td>No charge after the $15 per visit copay 100%</td>
<td>No charge after the $15 per visit copay 100%</td>
<td>80% of the Maximum Reimbursable Charge after plan deductible</td>
</tr>
<tr>
<td></td>
<td>(Dedicated Virtual Providers MDLIVE Behavioral Services)</td>
<td>(Outpatient - All Other Services)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc.)</td>
<td>(Calendar Year Maximum: Unlimited)</td>
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Open Access Plus Medical Benefits

Certification Requirements - Out-of-Network
For You and Your Dependents
Pre-Admission Certification/Continued Stay Review for Hospital Confinement
Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

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

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

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

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

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

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

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

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

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

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

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

Outpatient Diagnostic Testing and Outpatient Procedures
Including, but not limited to:

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

Prior Authorization/Pre-Authorized
The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays.
• inpatient services at any participating Other Health Care Facility.
• residential treatment.
• outpatient facility services.
• partial hospitalization.
• advanced radiological imaging.
• non-emergency Ambulance.
• certain Medical Pharmaceuticals.
• home health care services.
• radiation therapy.
• transplant services.

• charges for outpatient medical care and treatment received at a Free-Standing Surgical Facility.
• charges for Emergency Services.
• charges for Urgent Care.
• charges by a Physician or a Psychologist for professional services.
• charges by a Nurse for professional nursing service.
• charges for anesthetics, including, but not limited to supplies and their administration.
• charges for diagnostic x-ray.
• charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.
• charges for chemotherapy.
• charges for blood transfusions.
• charges for oxygen and other gases and their administration.
• charges for Medically Necessary foot care for diabetes, peripheral neuropathies, and peripheral vascular disease.
• charges for screening prostate-specific antigen (PSA) testing.
• charges for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
• charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
• charges for the following preventive care services as defined by recommendations from the following:
  • the U.S. Preventive Services Task Force (A and B recommendations);
  • the Advisory Committee on Immunization Practices (ACIP) for immunizations;
  • the American Academy of Pediatrics’ Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;
  • the Uniform Panel of the Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children; and
  • with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.

Covered Expenses

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

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

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

Covered Expenses

• charges for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital, subject to the limits as shown in The Schedule.
• charges for inpatient Room and Board and other Necessary Services and Supplies made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility as shown in The Schedule.
• charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
• charges for outpatient medical care and treatment received at a Hospital.
Detailed information is available at www.healthcare.gov. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.

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

- charges for surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).

- charges for acupuncture.

- charges for hearing aids and associated exam for device testing and fitting, 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.

- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.

- charges for the administration of the COVID-19 vaccine or screening and testing for COVID-19.

- abortion services.

- charges for laboratory testing expenses will be covered in full when recommended by a Physician for ongoing monitoring of HIV prevention drug treatment.

- charges for a drug prescribed for the treatment of cancer for a medically accepted indication, even if the drug has not been approved by the federal Food and Drug Administration for that indication. However, use of the drug must be a medically accepted indication for the treatment of cancer, in general. "Medically accepted indication" means another use of the drug if that use is supported by one or more citations in the standard reference compendia (the United States Pharmacopeia Drug Information or the American Hospital Formulary Service Drug Information) or the Plan, based on guidance from the federal Medicare program, determines such use is medically accepted based on supportive clinical evidence in peer-reviewed medical literature. Coverage includes Medically Necessary services given in connection with the administration of the drug.

- charges for a drug prescribed for the treatment of HIV or AIDS, even if the drug has not been approved by the federal Food and Drug Administration for that indication, as long as the drug is recognized for the treatment of that indication in one of the standard reference compendia (the United States Pharmacopeia Drug Information or the American Hospital Formulary Service Drug Information) or in peer-reviewed medical literature. Coverage includes Medically Necessary services given in connection with the administration of the drug.

- charges for laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability.

**Virtual Care**

**Dedicated Virtual Providers**

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

Includes charges for the delivery of mental health and substance use disorder-related services, consultations, and remote monitoring by dedicated virtual providers as appropriate through audio, video and secure internet-based technologies.

**Virtual Physician Services**

Includes charges for the delivery of real-time medical and health-related services, consultations and remote monitoring as medically appropriate through audio, video and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.

Includes charges for the delivery of real-time mental health and substance use disorder consultations and services, via secure telecommunications technologies that shall include video capability, telephone and internet, when such consultations and services are delivered by a behavioral provider and are similar to office visit services provided in a face-to-face setting.

**Convenience Care Clinic**

Convenience Care Clinics provide for common ailments and routine services, including but not limited to, strep throat, ear infections or pink eye, immunizations and flu shots.

**Nutritional Counseling**

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

**Enteral Nutrition**

Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism (e.g., disorders of amino acid or organic acid metabolism).
Internal Prosthetic/Medical Appliances
Charges for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

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

Home Health Care Services
Charges for skilled care provided by certain health care providers during a visit to the home, when the home is determined to be a medically appropriate setting for the services. A visit is defined as a period of 2 hours or less. Home Health Care Services are subject to a maximum of 16 hours in total per day.

Home Health Care Services are covered when skilled care is required under any of the following conditions:
- the required skilled care cannot be obtained in an outpatient facility.
- confinement in a Hospital or Other Health Care Facility is not required.

Hospice Care Services
Charges for services for a person diagnosed with advanced illness having a life expectancy of twelve or fewer months. Services provided by a Hospice Care Program are available to those who have ceased treatment and to those continuing to receive curative treatment and therapies.

Hospice Care Programs rendered by Hospice Facilities or Hospitals include services:
- by a Hospice Facility for Room and Board and Services and Supplies;
- by a Hospice Facility for services provided on an outpatient basis;
Mental Health and Substance Use Disorder Services

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

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

Inpatient Mental Health Services

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

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

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

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

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Partial Hospitalization or Intensive Outpatient Therapy Program.

Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

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

**Inpatient Substance Use Disorder Rehabilitation Services**

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

**Substance Use Disorder Residential Treatment Services**

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

**Substance Use Disorder Residential Treatment Center**

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

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

**Outpatient Substance Use Disorder Rehabilitation Services**

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

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

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

**Substance Use Disorder Detoxification Services**

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

**Exclusions**

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

- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

**Durable Medical Equipment**

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

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

- **Bed Related Items**: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.

- **Bath Related Items**: bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.

- **Fixtures to Real Property**: ceiling lifts and wheelchair ramps.

- **Car/Van Modifications**.

- **Air Quality Items**: room humidifiers, vaporizers and air purifiers.

- **Other Equipment**: centrifuges, needleless injectors, heat lamps, heating pads, cryounts, cryotherapy machines, ultraviolet cabinets, that emit Ultraviolet A (UVA) rays sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment and diathermy machines.

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**Orthoses and Orthotic Devices**

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

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.

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

The following are specifically excluded orthoses and orthotic devices:

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

**Braces**

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.
The following braces are specifically excluded: Copes scoliosis braces.

**Splints**
A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts. Coverage for replacement of external prosthetic appliances and devices is limited to the following:
- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- replacement due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited as follows:
- no more than once every 24 months for persons 19 years of age and older.
- no more than once every 12 months for persons 18 years of age and under.

The following are specifically excluded external prosthetic appliances and devices:
- external and internal power enhancements for external prosthetic devices; or
- microprocessor controlled prostheses and orthoses; and
- myoelectric prostheses and orthoses.

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

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

This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are specifically excluded infertility services:
- Infertility drugs;
- In vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;
- Donor charges and services;
- Cryopreservation of donor sperm and eggs; and
- Any experimental, investigational or unproven infertility procedures or therapies.

**Outpatient Therapy Services**
Charges for the following therapy services:
- Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy
- Charges for therapy services are covered when provided as part of a program of treatment.

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

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

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

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

- Restore function (called “rehabilitative”):
  - To restore function that has been impaired or lost.
  - To reduce pain as a result of Sickness, Injury, or loss of a body part.

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

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

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

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

Therapy services that are not covered include:

- sensory integration therapy.
- treatment of dyslexia.
- maintenance or preventive treatment provided to prevent recurrence or to maintain the patient’s current status.

- charges for Chiropractic Care not provided in an office setting.
- vitamin therapy.

Coverage is administered according to the following:

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

Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

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

Transplant Services and Related Specialty Care

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
Transplant and Related Specialty Care Travel Services

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

- Transplant and related specialty care travel benefits are not available for cornea transplants.
- Benefits for transportation and lodging are available to the recipient of a preapproved organ/tissue transplant and/or related specialty care 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 designated Cigna LifeSOURCE Transplant Network® facility (including charges for a rental car used during a period of care at the designated Cigna LifeSOURCE Transplant Network® facility); and lodging while at, or traveling to and from, the designated Cigna LifeSOURCE Transplant Network® facility.
- In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.
- The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits for Transplant Services and Related Specialty Care, and for Transplant and Related Specialty Care Travel Services are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant, the transplant recipient’s plan would cover all donor costs.
Medical Pharmaceuticals
The plan covers charges made for Medical Pharmaceuticals that are administered in an Inpatient setting, Outpatient setting, Physician’s office, or in a covered person's home.

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

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

Utilization management requirements or other coverage conditions are based on a number of factors, which may include clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee’s evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical’s cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

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

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

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

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

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

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

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

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

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

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

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

Clinical Trials

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

- the referring health care professional is a participating health care provider and has concluded that the individual’s participation in such trial would be appropriate; or
- the individual provides medical and scientific information establishing that the individual’s participation in the clinical trial would be appropriate.

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

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

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

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

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

Examples of routine patient care costs and services include:

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

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

• In-Network providers are not participating in the clinical trial; or
• the clinical trial is conducted outside the individual’s state of residence.
Prescription Drug Benefits
The Schedule

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

You and your Dependents will pay 100% of the cost of any Prescription Drug Product excluded from coverage under this plan. The amount you and your Dependent pays for any excluded Prescription Drug Product to the dispensing Pharmacy, will not count towards your Deductible, if any, or Out-of-Pocket Maximum.

Copayments (Copay)
Copayments are amounts to be paid by you or your Dependent for covered Prescription Drug Products.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are Covered Expenses incurred at a Pharmacy for Prescription Drug Products for which the Plan provides no payment 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>NETWORK PHARMACY</th>
<th>NON-NETWORK PHARMACY</th>
</tr>
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<tbody>
<tr>
<td>Out-of-Pocket Maximum</td>
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</tr>
<tr>
<td>Individual</td>
<td>$1,300 per person</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Family</td>
<td>$1,950 per family</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

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

Certain Preventive Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required.

Non-prescription smoking cessation drugs and Restasis are covered without prior authorization.
Preferred Brand and Generics for Diabetic supplies and medications are covered at no charge.

Prescription Drug Products at Retail Pharmacies
The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy
The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy

<table>
<thead>
<tr>
<th>Tier 1</th>
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<tbody>
<tr>
<td>Generic Preventive Drugs on the Prescription Drug List</td>
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<tr>
<td>Generic Non-Preventive Drugs on the Prescription Drug List</td>
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<tr>
<td>BENEFIT HIGHLIGHTS</td>
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<tr>
<td>Tier 2</td>
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<tr>
<td>Brand Drugs designated as preferred on the Prescription Drug List</td>
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<tr>
<td>Tier 3</td>
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<tr>
<td>Brand Drugs designated as non-preferred on the Prescription Drug List</td>
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<tr>
<td>Prescription Drug Products at Retail Pharmacies</td>
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<td>Prescription Drug Products at Home Delivery Pharmacies</td>
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<tr>
<td>Brand Drugs designated as non-preferred on the Prescription Drug List</td>
</tr>
</tbody>
</table>
Prescription Drug Benefits

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

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule. Your benefits may vary depending on which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

Coverage under your plan’s Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure. This includes:

- the Network Pharmacy’s submitted Usual and Customary (U&C) Charge, if any.
- charges for one type of covered HIV infection prevention drugs (pre-exposure prophylaxis, post-exposure prophylaxis, or other drugs approved by the FDA for the prevention of HIV infection) at no cost share.
- charges for abuse-deterrent opioid analgesic drug products.

When you or a Dependent are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered pursuant to the, as applicable, Copayment or Coinsurance for the Prescription Drug Product when dispensed by a Network Pharmacy.

Prescription Drug List Management
Your plan’s Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. Determination of inclusion of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and utilization management requirements or other coverage conditions are based on a number of factors which may include, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee’s evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy (ies) for coverage, or try another covered Prescription Drug Product(s).

Please access the internet through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

Formulary Exception Process
- Cigna allows an enrollee, the enrollee's designee or the person who has issued a valid prescription for the enrollee to request and gain access to a clinically appropriate drug not otherwise covered by the health plan. This process complies with the state's utilization review requirements and this law.
- If Cigna approves a request under this law for a drug not otherwise covered by the health plan, Cigna will treat the drug as an essential health benefit, including counting any cost sharing toward the plan's annual limit on cost sharing (out of pocket) and including it when calculating the plan's actuarial value.
- Cigna will determine whether it will cover the drug requested and notify the enrollee, the enrollee's designee, if applicable, and the person who has issued the valid prescription for the enrollee of its coverage decision within 72 hours or 2 business days, whichever is less, following receipt of the request. If the request is approved, Cigna will

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provide coverage of the drug for the duration of the prescription, including refills.

- Cigna has a process by which an expedited review may be requested in urgent circumstances. Urgent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. When an expedited review has been requested, Cigna will determine whether it will cover the drug requested and notify the enrollee, the enrollee's designee, if applicable, and the person who has provided a valid prescription for the enrollee of its coverage decision within 24 hours following receipt of the request. If the request is approved, Cigna, will provide coverage of the drug for the duration of the urgency.

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

**Limitations**

For most Prescription Drug Products you and your Dependent pay only the cost sharing detailed in The Schedule of Prescription Drug Benefits. However, in the event you or your Dependent insist on a more expensive Brand Drug where a Therapeutic Equivalent Generic Drug is available, you may be financially responsible for an Ancillary Charge, in addition to any required Brand Drug Copayment and/or Coinsurance. In this case, the Ancillary Charge will not apply to your Deductible, if any, or Out of Pocket Maximum. However, in the event your Physician determines that the Generic Drug is not an acceptable alternative for you (and indicates Dispensed as Written on the Prescription Order or Refill), you will only be responsible for payment of the appropriate Brand Drug Copayment and/or Coinsurance after satisfying your Deductible, if any.

Your plan includes a Brand Drug for Generic Drug dispensing program. This program allows certain Brand Drugs to be dispensed in place of the Therapeutic Equivalent Generic Drug at the time your Prescription Order or Refill is processed by a participating Pharmacy. Brand Drug for Generic Drug substitution will occur only for certain Brand Drugs included in the program. When this substitution program is applied, the participating Pharmacy will dispense the Brand Drug to you in place of the available Generic Drug. You will be responsible for payment of only a Generic Drug Copayment and/or Coinsurance, after satisfying your Deductible, if any.

**Prior Authorization Requirements**

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

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

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

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

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

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

**Step Therapy**

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

**Supply Limits**

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

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee’s clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

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

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

A pharmacist may partially dispense a prescription for an opioid medication in a lesser quantity than the recommended full quantity indicated on the prescription if requested by the patient for whom the prescription is written. The remaining quantity of the prescription is void and may not be dispensed without a new prescription.

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

**Specialty Prescription Drug Products**

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products.

**Designated Pharmacies**

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

**New Prescription Drug Products**

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

**Emergency Order**

During a statewide state of emergency declared by the Governor, a prescription drug is covered in accordance with a valid prescription issued by a provider in a quantity sufficient for an extended period of time, not to exceed a 180-day supply. This does not apply to coverage of prescribed contraceptive supplies according to state law or coverage of opioids prescribed in accordance with limits set by state law.

**Prescription Eye Drops**

For prescription eye drops, an early refill will be allowed when the insured requests the refill no earlier than the date on which 70% of the days of use authorized by the prescribing health care provider have elapsed; the prescriber indicated on
the original prescription that a specific number of refills are authorized; the refill requested by the insured does not exceed the number of refills indicated on the original prescription; the prescription has not been refilled more than once during the period authorized by the prescribing health care provider prior to the request for an early refill and the prescription eye drops are a covered benefit under the insured’s health plan.

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

- coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.
- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products dispensed outside the jurisdiction of the United States, except as required for emergency or Urgent Care treatment.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- medications used for cosmetic purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth and fade cream products.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products used for the treatment of infertility.
- Medical Pharmaceuticals covered solely under the plan’s medical benefits.
any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).

• medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.

• certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.

• any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.

• medications used for travel prophylaxis, unless specifically identified on the Prescription Drug List.

• immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions unless specifically identified on the Prescription Drug List.

• certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.

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

Prescription Drug Product at a Network Pharmacy and later seek reimbursement for the Prescription Drug Product under the plan. For example, if you must pay the full cost of a Prescription Drug Product to the retail Network Pharmacy because you did not have your ID card, then you must submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. If, under this example, your payment to the retail Network Pharmacy for the covered Prescription Drug Product exceeds any applicable copay, then you will be reimbursed the difference, if any, between the applicable copay and the Prescription Drug Charge for the Prescription Drug Product.

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

• care for health conditions that are required by state or local law to be treated in a public facility.

• care required by state or federal law to be supplied by a public school system or school district.

• care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.

• treatment of an Injury or Sickness which is due to war, declared, or undeclared.

• charges which you are not obligated to pay and/or for which you are not billed. This exclusion includes, but is not limited to:

  • any instance where Cigna determines that a provider or Pharmacy did not bill you for or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.

  • charges of a non-Participating Provider who has agreed to charge you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.

Reimbursement/Filing a Claim

Retail Pharmacy

When you or your Dependents purchase your Prescription Drug Products through a Network Pharmacy, you pay any applicable Copayment, Coinsurance, or Deductible shown in The Schedule at the time of purchase. You do not need to file a claim form for a Prescription Drug Product obtained at a Network Pharmacy unless you pay the full cost of a
• In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:
  • require you and/or any provider or Pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna.
  • deny the payment of benefits in connection with the Covered Expense regardless of whether the provider or the Pharmacy represents that you remain responsible for any amounts that your plan does not cover, or
  • reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover.
  • charges or payment for healthcare-related services that violate state or federal law.
  • assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
  • for or in connection with experimental, investigational or unproven services.
Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
  • not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  • not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  • the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” sections of this plan; or
  • the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” sections of this plan.
In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.
• cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
• the following services are excluded from coverage regardless of clinical indications: abdominoplasty; panniculectomy; redundant skin surgery; acupressure; craniocerebral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolling; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
• dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered if the continuous course of dental treatment is started within six months of an accident. Additionally, charges made by a Physician for any of the following surgical procedures are covered: excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth).
• for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the Body Mass Index (BMI) classifications of the National Heart, Lung, and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:
  • medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and
  • weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
• reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government

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licensess, and court-ordered, forensic or custodial evaluations, unless otherwise covered under this plan.

- court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan.
- for treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction, anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under this plan.
- non-medical counseling and/or ancillary services, including but not limited to Custodial Services, educational services, vocational counseling, training and, rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Care Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Care Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids, including but not limited to garter belts, corsets and dentures.
- aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames, contact lenses and associated services (exams and fittings) (except for the initial set after treatment of keratoconus or following cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- all non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.
- membership costs and fees associated with health clubs, weight loss programs or smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are medications for the purpose of travel, or to protect against occupational hazards and risks.
- health and beauty aids, cosmetics and dietary supplements.
- all nutritional supplements, formulae, enteral feedings, supplies and specially formulated medical foods, whether prescribed or not except for infant formula needed for the treatment of inborn errors of metabolism and specially modified low-protein food products.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges related to an Injury or Sickness payable under worker’s compensation or similar laws.
- massage therapy, except as shown in The Schedule.
- products and supplies associated with the administration of medications that are available to be covered under the Prescription Drug Benefit. Such products and supplies include but are not limited to therapeutic Continuous
Glucose Monitor (CGM) sensors and transmitters and insulin pods.

- expenses incurred by a participant to the extent reimbursable under automobile insurance coverage. Coverage under this plan is secondary to automobile no-fault insurance or similar coverage. The coverage provided under this plan does not constitute “Qualified Health Coverage” under Michigan law and therefore does not replace Personal Injury Protection (PIP) coverage provided under an automobile insurance policy issued to a Michigan resident. This plan will cover expenses only not otherwise covered by the PIP coverage.

**General Limitations**

No payment will be made for expenses incurred for you or any one of your Dependents:
- for charges by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- any charges related to care provided through a public program, other than Medicaid.
- for charges which would not have been made if the person did not have coverage.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for services, supplies, care, treatment, drugs or surgery that are not Medically Necessary.
- charges by any Physician or Other Health Professional who is a member of your family or your Dependent's family.
- expenses incurred outside the United States other than expenses for Medically Necessary emergency or urgent care while temporarily traveling abroad.

**Definitions**

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

**Plan**

Any of the following that provides benefits or services for medical care or treatment:
- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

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

**Closed Panel Plan**

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

**Primary Plan**

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

**Secondary Plan**

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

**Allowable Expense**

The amount of charges considered for payment under the Plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity’s contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit. Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:
- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.

**Coordination of Benefits**

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.
• If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.

• If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

• If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

• If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

**Reasonable Cash Value**

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

**Order of Benefit Determination Rules**

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

• The Plan that covers you as an enrollee or an Employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;

• If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or Employee;

• If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  • first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  • then, the Plan of the parent with custody of the child;

• then, the Plan of the spouse of the parent with custody of the child;

• then, the Plan of the parent not having custody of the child; and

• finally, the Plan of the spouse of the parent not having custody of the child.

• The Plan that covers you as an active Employee (or as that Employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired Employee (or as that Employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

• The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active Employee or retiree (or as that Employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

• If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

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

**Effect on the Benefits of This Plan**

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

**Recovery of Excess Benefits**

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services. Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare Plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.
Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 55 days of the request, the claim will be closed. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles

The Medical Insurance for a person who is eligible for Medicare will be modified as follows:

The amount payable under this plan will be reduced so that the total amount payable by Cigna and Medicare will be no more than 100% of the expenses incurred. This provision will not apply to a person while Medicare, based on the rules established by the Social Security Act of 1965 as amended, is assuming the role of secondary payer to this plan for that person.

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.

Domestic Partners

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

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

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

Subrogation/Right of Reimbursement

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

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

Lien of the Plan

By accepting benefits under this plan, a Participant:

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

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

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

**Additional Terms**

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

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

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

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

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

- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan’s subrogation or recovery rights are neither affected nor diminished by equitable defenses.

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

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

- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

**Payment of Benefits**

**Assignment and Payment of Benefits**

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

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

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

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

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

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

**Recovery of Overpayment**

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

**Calculation of Covered Expenses**

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

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

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**Termination of Insurance**

**Employees**

Your insurance will cease on the earliest date below:

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

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

**Temporary Layoff or Leave of Absence**

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

**Injury or Sickness**

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer cancels your insurance.

**Retirement**

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer cancels the insurance.

**Dependents**

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

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

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.
Rescissions
Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

Medical Benefits Extension During Hospital Confinement
If the Medical Benefits under this plan cease for you or your Dependent, and you or your Dependent is Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:
- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group plan;
- the date you or your Dependent is no longer Hospital Confined; or
- 3 months from the date your Medical Benefits cease.
The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when your Medical Benefits cease or your Dependent's Medical Benefits cease.

Medical Benefits Extension Upon Policy Cancellation
If the Medical Benefits under this plan cease for you due to cancellation of the policy, and Totally Disabled on that date due to an Injury or Sickness, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:
- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group policy; except Cigna will pay benefits as secondary payer in coordination with the succeeding plan;
- the date you are no longer Totally Disabled or no longer Confined in a Hospital;
- 6 months from the date your Medical Benefits cease; or
- 6 months from the date the policy is canceled.

Totally Disabled
You will be considered Totally Disabled if, because of an Injury or a Sickness:
- you are unable to perform the basic duties of your occupation.

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

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

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

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

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

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

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child’s custodial parent or legal guardian, shall be made to the child, the child’s custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

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

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

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

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

- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible
Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:

- divorce or legal separation;
- cessation of Dependent status (such as reaching the limiting age);
- death of the Employee;
- termination of employment;
- reduction in work hours to below the minimum required for eligibility;
- you or your Dependent(s) no longer reside, live or work in the other plan’s network service area and no other coverage is available under the other plan;
- you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
- the other plan no longer offers any benefits to a class of similarly situated individuals.

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

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

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

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

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

**Effect of Section 125 Tax Regulations on This Plan**

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

**A. Coverage elections**

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed:

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

**B. Change of status**

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
• change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;

• changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;

• change in residence of Employee, spouse or Dependent to a location outside of the Employer’s network service area; and

• changes which cause a Dependent to become eligible or ineligible for coverage.

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

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

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

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

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

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

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

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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.

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Coverage for Maternity Hospital Stay
Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.
In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

**Women’s Health and Cancer Rights Act (WHCRA)**

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

**Group Plan Coverage Instead of Medicaid**

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

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

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

**Continuation of Health Insurance During Leave**

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

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and

- you are an eligible Employee under the terms of that Act.

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

**Reinstatement of Canceled Insurance Following Leave**

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

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

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

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

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

**Continuation of Coverage**

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

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

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

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

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

**Reinstatement of Benefits (applicable to all coverages)**

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

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

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

Claim Determination Procedures

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

Procedures Regarding Medical Necessity Determinations

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

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

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

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

Preservice Determinations

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

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

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

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

Concurrent Determinations

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

Postservice Determinations

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

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

Notice of Adverse Determination

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

Appointment of Authorized Representative

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

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

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

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

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

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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 area, if the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your area.

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

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

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

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

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

First payment for COBRA continuation

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

Subsequent payments

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

Grace periods for subsequent payments

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

You Must Give Notice of Certain Qualifying Events

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

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

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

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

Newly Acquired Dependents

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

COBRA Continuation for Retirees Following Employer’s Bankruptcy

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

Interaction With Other Continuation Benefits

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

When You Have An Appeal Or Grievance

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

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

Requests for Reconsideration
In a case involving a health care treatment decision or a concurrent review decision, Cigna shall give the provider rendering the service an opportunity to request by telephone, fax or in writing on behalf of the covered person a reconsideration of an adverse decision by the reviewer making the adverse decision.

The reconsideration shall occur within one working day after the receipt of the request and shall be conducted between the provider rendering the service and the reviewer who made the adverse health care treatment decision or a clinical peer designated by the reviewer if the reviewer who made the adverse decision cannot be available within one working day.

If the reconsideration process does not resolve the difference of opinion, the adverse health care treatment decision may be appealed by the covered person or the provider on behalf of the covered person. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an adverse decision.

Appeals of Adverse Health Care Treatment Decisions
An adverse health care treatment decision is a health care treatment decision made by or on behalf of Cigna that denies payment for or provision of a service otherwise covered under the Plan (in whole or in part), when that service is requested by you or on your behalf. A health care treatment decision means a benefit decision involving determinations regarding Medically Necessary health care and determinations regarding experimental or investigational services. It also include a rescission determination, consistent with the requirements of the federal Affordable Care Act.

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

Cigna
National Appeals Organization (NAO)
P.O. Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at 1-800-244-6224 or the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

We will provide notice to you of the following rights within three working days after we receive your appeal:

- You have the right to review your claim file and to present evidence and testimony as part of the internal appeals process.
- We will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by us (or at our direction) in connection with your claim. We will provide such evidence as soon as possible and sufficiently in advance of the decision to give you a reasonable opportunity to respond.
- We will provide you the name, address and telephone number of the person designated to coordinate the appeal on Cigna's behalf.

Standard Appeal of an Adverse Health Care Treatment Decision
A standard appeal of an adverse health care treatment decision will be evaluated by an appropriate clinical peer or peers. The clinical peer shall not have been involved in the initial adverse determination, unless the appeal presents additional information that the clinical peer was not aware of at the time of the initial adverse health care treatment decision. The clinical peer will not be a subordinate of a clinical peer involved in the prior decision.

You and your attending or ordering provider will be notified, in writing, of the results of the standard appeal of an adverse determination review within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

If a standard appeal of an adverse health care treatment decision is denied by Cigna, the Adverse Health Care Treatment appeal Decision provided to you and your attending or ordering provider will contain:

- The names, titles and qualifying credentials of the person(s) evaluating the appeal.
- A statement of the appeal reviewer’s understanding of the reason for the request for appeal.
• Reference to the specific plan provisions upon which the decision is based.
• The appeal reviewer’s decision in clear terms and the clinical rationale, in sufficient detail, so that you may respond further to Cigna, if necessary.
• A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination. The decision will include: instructions for requesting copies (free of charge) of information relevant to the claim, including any referenced evidence, documentation or clinical review criteria not previously provided to you; or the actual copies of such additional clinical review criteria, if you previously submitted a written request for the clinical review criteria used in the initial adverse health care treatment decision.
• If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit decision, either: the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse decision. Copies will be provided to you, free of charge, upon request.
• Notice of any subsequent appeal rights available to you, and the procedure and time limitation for exercising those rights.
• Notice of the availability of any applicable office if health insurance consumer assistance or ombudsman established under the federal Affordable Care Act.
• Notice of your right to contact the Maine Insurance Superintendent’s office. (See the provision Assistance from the State of Maine.)

Expedited Appeal of an Adverse Health Care Treatment Decision

An expedited appeal of an adverse health care treatment decision is available to you, or to a provider acting on your behalf, when the time frame for the standard appeal of an adverse health care treatment decision would seriously jeopardize your life or health, or your ability to regain maximum function. If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited appeal would be detrimental to your medical condition.

Additionally, Cigna will provide expedited review to all requests concerning an admission, availability of care, continued stay or a health care services if you have received Emergency Services, but have not been discharged from a health care facility.

An expedited appeal will be evaluated by an appropriate clinical peer or peers. The clinical peer shall not have been involved in the initial adverse health care treatment decision.

The clinical peer may not be a subordinate of the clinical peer involved in the prior decision.

All information necessary to the expedited review, including Cigna’s decision, will be transmitted between all parties by telephone, facsimile, electronic means or the most expeditious method available.

Cigna will make a decision as expeditiously as your medical condition requires, but in no event more than 72 hours after the expedited appeal is initiated. Cigna will notify you and a provider acting on your behalf via telephone. Written confirmation will be provided within two working days of any notification provided by other means.

If the expedited appeal is in connection with: a concurrent review determination of Emergency Services; or an initially authorized admission or course of treatment, the service will be continued without liability to you until you have been notified of the expedited appeal determination.

If an expedited appeal of an adverse health care treatment decision is denied by Cigna, the adverse appeal decision provided to you and your attending or ordering provider will contain the same items outlined above that are provided for a standard appeal denial.

Expedited appeal review will not be provided for retrospective adverse health care treatment decisions.

Second Level Appeals of Adverse Health Care Treatment Decisions

Cigna provides you with an opportunity for a second level appeal when you are dissatisfied with a first level appeal decision.

When requesting a second level appeal, you have a right to appear in person before authorized Cigna representatives. Cigna will provide you adequate notice of this option.

Cigna will appoint a panel for each second level appeal, which will include one or more panelists who are disinterested clinical peers (that is, a peer not involved in the prior decision, who is not a subordinate of a panelist involved in the prior decision, and has no financial or other personal interest in the outcome of the review). If the second level appeal decision is adverse to you, the decision must have the concurrence of a majority of the disinterested clinical peers on the panel.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the second level appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the panel’s decision, so that you will have the opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the panel’s decision so that you will have the opportunity to respond.
When you request the opportunity to appear in person before Cigna-authorized representatives, Cigna’s procedures for conducting a second level panel review will include the following:

- For required preservice and concurrent care coverage determinations, the panel review will be completed within 15 calendar days, and for postservice claims, the panel review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the panel to complete the review.

- The review meeting will be held during regular business hours at a location reasonably accessible to you. Cigna will offer you the opportunity to communicate with the review panel, at Cigna's expense, by conference call, video conferencing, or other appropriate technology. You will be notified in writing at least 15 days in advance of the review date. Cigna will not unreasonably deny your request for postponement of the review.

- Upon your request, Cigna will provide to you all relevant information that is not confidential and privileged from disclosure to you.

- You have the right to:
  - Attend the second level review;
  - Present your case to the review panel;
  - Submit supporting material both before and at the review meeting;
  - Ask questions of any Cigna representative;
  - Be assisted or represented by a person of your choice; and
  - Obtain your medical file and information relevant to the appeal free of charge upon request.

- If Cigna has an attorney present to argue its case, Cigna will so notify you at least 15 days in advance of the review, and will advise you of your right to obtain legal representation.

- Your right to a fair review is not conditional on your appearance at the review.

- The review panel will issue a written decision to you within 5 working days after completing the review meeting and within the panel time frames above if the panel does not approve the requested coverage. A decision adverse to you will contain the same items outlined above that are provided for a standard appeal denial.

Even if you choose not to appear in person before Cigna-authorized representatives, for required preservice and concurrent care coverage determinations, the panel review will be completed within 15 calendar days, and for postservice claims, the panel review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the panel to complete the review.

**Review of Adverse Benefit Decisions Not Involving Health Care Treatment Decisions**

For any adverse benefit determination that does not involve medical issues, we will provide written notice to you that includes the following information:

- The principal reason or reasons for the determination.
- Reference to the specific plan provisions on which the determination is based.
- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning will be provided upon request.
- A description of any additional material or information necessary for you to perfect the claim and an explanation as to why such material or information is necessary.
- The instructions and time limits for initiating an appeal or reconsideration of the determination.
- Notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under Cigna's internal review process. In addition, an explanation of benefits (EOB) must comply with Maine requirements.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination. We will provide a copy to you free of charge upon request.
- The phone number you may call for information on and assistance with initiating an appeal or reconsideration or requesting review criteria.
- A description of the expedited review process applicable to claims involving urgent care.
- The availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act.
- Any other information required pursuant to the federal Affordable Care Act.

**First Level Review of Adverse Benefit Determinations Not Involving Health Care Treatment Decisions**
A grievance concerning any matter may be submitted by you or a representative of your choice. A grievance is a written complaint submitted by you or on your behalf regarding the:

- Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between you and Cigna.

You may not attend a first level grievance review (or have a representative attend in your place), but you may submit written material to the reviewer at the first level grievance review. Within three working days of receiving a grievance, Cigna will provide you with the name, address and telephone number of a person designated to coordinate the grievance review.

Cigna will issue to you a written decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a postservice coverage determination. The person reviewing the grievance will not be the same person who made the initial determination denying the claim or handling the matter that is the subject of the grievance.

If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

If the decision is adverse to you, the written decision will contain:

- The names, titles and qualifying credentials of the person(s) participating in the first level grievance review process (the reviewers).
- A statement of the reviewers’ understanding of your grievance and all pertinent facts.
- Reference to the specific plan provisions on which the benefit determination is based.
- The reviewers’ decision in clear terms, including the specific reason or reasons for the adverse benefit determination.
- A reference to the evidence or documentation used as the basis for the decision. The decision will include: instructions for requesting copies (free of charge) of information relevant to the claim, including any referenced evidence or documentation not previously provided to you.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit decision, either: the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination. Copies will be provided to you, free of charge, upon request.
- A description of the process to obtain a second level grievance review and the procedures and time frames governing a second level grievance review, along with notice of subsequent external review rights.
- Notice of the availability of any applicable office if health insurance consumer assistance or ombudsman established under the federal Affordable Care Act.
- Notice of your right to contact the Maine Insurance Superintendent’s office. (See the provision Assistance from the State of Maine.)

Second Level Review of Adverse Benefit Determinations not Involving Health Care Treatment Decisions

Cigna will provide a second level grievance review process to you if you are dissatisfied with a first level grievance review determination. You have the right to appear in person before Cigna-authorized representatives, and we will provide you adequate notice of that option.

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

Cigna will appoint a second level grievance review panel for your grievance. A majority of the panel will consist of Cigna employees or representatives who were not previously involved in the grievance.

When you decide not to appear in person before Cigna-authorized representatives, the decision will be issued within 30 calendar days.

When you request the opportunity to appear in person before Cigna-authorized representatives, Cigna’s procedures for conducting a second level panel review will include the following:

- The review panel will schedule and hold a review meeting within 45 days of your request. For required preservice and concurrent care coverage determinations, the review will be completed within 15 calendar days and for postservice claims, the review will be completed within 30 calendar days. The review meeting will be held during regular business hours at a location reasonably accessible to you. Cigna will offer you the opportunity to communicate with
you and Cigna mutually agreed to bypass the appeals procedure; (c) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (d) the patient has died.

You may call Cigna at 1-800-244-6224 or the toll-free telephone number on your ID card for assistance in filing a request for an independent review with the Maine's Bureau of Insurance. There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization. The Independent Review Program is a voluntary program arranged by Cigna. You may also call Maine's Bureau of Insurance at 1-800-300-5000 for assistance.

**Assistance from the State of Maine**

You have the right to contact the Maine Superintendent of Insurance for assistance at any time. The Maine Superintendent of Insurance may be contacted at the following address and telephone number:

State of Maine
Maine Bureau of Insurance
Superintendent of Insurance
34 State House Station
Augusta, ME 04333
1-800-300-5000

**Notice of Benefit Determination on Appeal**

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) 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; (5) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to bring an action under ERISA section 502(a); (6) 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 (7) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative procedures available to you.
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 (a) was relied upon in making the benefit determination; (b) 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; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) 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.

**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 as determined by your Employer 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.

**Ambulance**

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

**Ancillary Charge**

An additional cost, outside of plan cost sharing detailed in The Schedule of Prescription Drug Benefits, which may apply to some Prescription Drug Products when you request a more expensive Brand Drug when a lower cost, Therapeutic Equivalent, Generic Drug is available. The Ancillary Charge is the amount by which the cost of the requested Brand Drug exceeds the cost of the Generic Drug.

**Biologic**

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

**Biosimilar**

A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).
Brand Drug
A Prescription Drug Product that Cigna identifies as a Brand Drug product across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the plan.

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

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

Cigna Care Network
The term Cigna Care Network refers to a designation given to Participating Providers who meet independently-established criteria determining efficiency and quality.

Convenience Care Clinics
Convenience Care Clinics are staffed by nurse practitioners and physician assistants and offer customers convenient, professional walk-in care for common ailments and routine services. Convenience Care Clinics have extended hours and are located in or near easy-to-access, popular locations (pharmacies, grocery and free-standing locations) with or without appointment.

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

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

Dependent
Dependants are:
- The subscriber's lawful spouse;
- The subscriber's domestic partner who meets the University's criteria and files a University Affidavit of Domestic Partnership.
- The subscriber's children (biological, adopted or stepchildren) who are under age 26;
- The children of a previously approved domestic partner, provided they satisfy the eligibility requirements;
- A visiting foreign student who is under age 26, living with the subscriber in a parent-child relationship and 50% or more dependent on the subscriber for financial support; and
A child for whom the subscriber has been appointed legal guardian, living with the subscriber in a parent-child relationship.

A subscriber's grandchild under age 26, living with the subscriber in a parent-child relationship. The subscriber cannot enroll a child and grandchild at the same time under the same policy number. The eligible child or grandchild can be covered under a separate University of Maine System comprehensive policy number.

A child for whom the subscriber has received a qualified court order to provide coverage; or

A child 26 years of age or older and primarily supported by you, incapable of self-sustaining employment because of physical or mental handicap. The disability must have begun before the child's 26th birthday and the child must have been covered under the Plan continuously since his or her 26th birthday. You must submit proof of the child's condition within 31 days of his or her 26th birthday. We reserve the right to require ongoing proof of the mental or physical incapacity.

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**Designated Pharmacy**

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

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**Domestic Partner**

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

- resides with you;
- is not married to anyone else;
- is no less than 18 years of age;
- is mentally competent to consent to contract;
- is not a blood relative any closer than would prohibit legal marriage;
- is your sole domestic partner and intends to remain so indefinitely; and
- shares the responsibility of each other’s common welfare and financial obligations.

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

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**Emergency Medical Condition**

Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

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**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 or of an independent freestanding emergency facility, 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.

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**Employee**

The term Employee means an Employee as determined by your Employer who is currently in Active Service.
Employer
The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf Cigna is providing claim administration services.

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

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

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

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

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

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

Hospice Care Services
The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.
**Hospice Facility**
The term Hospice Facility means an institution or part of it which:
- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

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

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

**Injury**
The term Injury means an accidental bodily injury.

**Maintenance Drug Product**
A Prescription Drug Product that is prescribed for use over an extended period of time for the treatment of chronic or long-term conditions such as asthma, hypertension, diabetes and heart disease, and is identified principally based on consideration of available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source and clinical factors. For the purposes of benefits, the list of your plan’s Maintenance Drug Products does not include compounded medications, Specialty Prescription Drug Products or Prescription Drug Products, such as certain narcotics that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or Refill under applicable federal or state law. You may determine whether a drug is a Maintenance Medication by calling member services at the telephone number on your ID card.

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

The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule. You may be subject to balance billing from a non-Participating Provider as a result of a claims adjustment.

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;
- the amount agreed to by the Out-of-Network provider and Cigna; or
the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.

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

Medicaid
The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medical Pharmaceutical
Medical Pharmaceuticals are used for treatment of complex chronic conditions, are administered and handled in a specialized manner, and may be high cost. Because of their characteristics, they require a qualified Physician to administer or directly supervise administration. Some Medical Pharmaceuticals may initially or typically require Physician oversight but subsequently may be self-administered under certain conditions specified in the product’s FDA labeling.

Medically Necessary/Medical Necessity
Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:
- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or Other Health Professional;
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

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

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

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.
Network Pharmacy
A retail or home delivery Pharmacy that has:
- entered into an agreement with Cigna or an entity contracting on Cigna's behalf to provide Prescription Drug Products to plan enrollees.
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- been designated as a Network Pharmacy for the purposes of coverage under your Employer’s plan.
This term may also include, as applicable, an entity that has directly or indirectly contracted with Cigna to arrange for the provision of any Prescription Drug Products the charges for which are Covered Expenses.

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

Other Health Professional
The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

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

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

Other Health Care Facility
The term Other Health Care Facility means a facility other than a Hospital or Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

Pharmacy & Therapeutics (P&T) Committee
A committee comprised of physicians and an independent pharmacist that represent a range of clinical specialties. The
committee regularly reviews Medical Pharmaceuticals or Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage determinations made by the Business Decision Team. The P&T Committee’s review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

**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, including but not limited to naturopathic providers, physician assistants, registered nurse first assistants, certified nurse first assistants and certified registered nurse anesthetists 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 Charge**
The Prescription Drug Charge is the amount that, prior to application of the plan’s cost-share requirement(s), the plan sponsor is obligated to pay for a covered Prescription Drug Product dispensed at a Network Pharmacy, including any applicable dispensing fee and tax.

**Prescription Drug List**
A list that categorizes drugs, Biologics (including Biosimilars) or other products covered under the plan’s Prescription Drug benefits that have been approved by the U.S. Food and Drug Administration (FDA) into coverage tiers. This list is adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.

**Prescription Drug Product**
A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of benefits under the plan, this definition may also include products in the following categories if specifically identified in the Prescription Drug List:

- Certain durable products and supplies that support drug therapy;
- Certain diagnostic testing and screening services that support drug therapy;
- Certain medication consultation and other medication administration services that support drug therapy; and
- Certain digital products, applications, electronic devices, software and cloud based service solutions used to predict, detect and monitor health conditions in support of drug therapy.

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

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the
comprehensive guidelines supported by the Health Resources and Services Administration.

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

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

**Primary Care Physician**

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice OB/GYN or pediatrics; and who has been voluntarily selected by you and is contracted as a Primary Care Physician with, 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.

**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.

**Review Organization**

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

**Room and Board**

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

**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.

**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.
Specialty Prescription Drug Product

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

Therapeutic Equivalent

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

Tiered Benefits

This plan includes tiered benefits for certain covered services identified in The Schedule rendered by Participating Providers. Under tiered benefits, you pay a lower Copayment or Coinsurance level for certain covered services rendered by Tier 1-identified Participating Providers than if you receive the same covered services from a Participating Provider that is not identified by Cigna as a Tier 1 Participating Provider. Cigna identifies Participating Providers as “Tier 1” based on consideration of criteria used to measure cost-efficiency and quality and consideration of other factors, including, but not limited to, local market need. Refer to The Schedule to identify the covered services that are subject to tiered benefits. In order to receive a higher level of In-Network benefits for covered services identified in The Schedule as subject to a tiered benefit, you should also verify that your Primary Care Physician or, as applicable, Specialist has been designated by Cigna as a Tier 1 Participating Provider. Participating Provider tier designations are assessed and may change annually. You can access a list of all Participating Providers by visiting www.cigna.com; or mycigna.com; or by calling the toll-free telephone number on your ID card. Tier 1 Participating Providers are specifically identified in this listing.

Therapeutic Alternative

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

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