Hillsborough Community College

OPEN ACCESS PLUS MEDICAL BENEFITS
Health Savings Account

EFFECTIVE DATE: July 1, 2011

CN005
3333178

This document printed in May, 2011 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
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CONNECTICUT GENERAL LIFE INSURANCE COMPANY
a CIGNA company (called CG) certifies that it insures certain Employees for the benefits provided by the
following policy(s):

POLICYHOLDER: Hillsborough Community College

GROUP POLICY(S) — COVERAGE
3333178 - HSAF, HSAI  OPEN ACCESS PLUS MEDICAL BENEFITS

EFFECTIVE DATE: July 1, 2011

CERTIFICATEHOLDER:

THE MEDICAL BENEFITS IN THIS CERTIFICATE CONTAIN A DEDUCTIBLE PROVISION.

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

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

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

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

CIGNA'S Toll-Free Care Line
CIGNA's toll-free care line allows you to talk to a health care professional during normal business hours, Monday through Friday, simply by calling the toll-free number shown on your ID card.

CIGNA's toll-free care line personnel can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may consult your Physician Guide which lists the Participating Providers in your area or call CIGNA's toll-free number for assistance. If you or your Dependents need medical care while away from home, you may have access to a national network of Participating Providers through CIGNA's Away-From-Home Care feature. Call CIGNA's toll-free care line for the names of Participating Providers in other network areas. Whether you obtain the name of a Participating Provider from your Physician Guide or through the care line, it is recommended that prior to making an appointment you call the provider to confirm that he or she is a current participant in the Open Access Plus Program.

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 as 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.

1. 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.

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

3. 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.

4. 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.

5. 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).

6. 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).

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

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

Additional Programs
We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well being of our members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

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 CG for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Changing Primary Care Physicians:
You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

Important Notices
Patient Protection and Affordable Care Act
Endorsement
The group contract or certificate is amended as stated below.

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

Definitions
“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 1) 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; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

“Emergency services” means, with respect to an emergency medical condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) 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.

“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.

“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).

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

**Lifetime Dollar Limits**

Any lifetime limit on the aggregate dollar value of essential health benefits is deleted. Any lifetime limits on the dollar value of any essential health benefits are deleted.

**Annual Dollar Limits**

Any annual limits on the dollar value of essential health benefits are deleted.

**Rescissions**

Your coverage may not be rescinded (retroactively terminated) unless: (1) 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 (2) the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

**Extension of Coverage to Dependents**

Dependent children are eligible for coverage up to the age of 26. Any restrictions in the definition of Dependent in your plan document which require a child to be unmarried, a student, financially dependent on the employee, etc. no longer apply. If the definition of Dependent in the plan document provides coverage for a child beyond age 26, the provision and all restrictions will continue to apply starting at age 26. Any provisions related to coverage of a handicapped child continue to apply starting at age 26.

**Preventive Services**

In addition to any other preventive care services described in the plan documents, no deductible, copayment, or coinsurance shall apply to the following Covered Services.

However, the covered services must be provided by a Participating Provider:

(1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of

the Centers for Disease Control and Prevention with respect to the Covered Person involved;

(3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

(4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

**Preservice Medical Necessity Determinations**

If standard determination periods would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, the preservice determination will be made on an expedited basis. The Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. You or your representative will be notified of an expedited determination within 24 hours after receipt of the request.

**Notice of Adverse Determination**

In addition to the description provided in your plan documents, a notice of adverse benefit determination will also include information sufficient for you to identify the claim, and information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process. In the case of a final adverse benefit determination, your notice will include a discussion of the decision.

**Right to Appeal**

You have the right to appeal any decision or action taken to deny, reduce, or terminate the provision of or payment for health care services covered by your plan or to rescind your coverage. When a requested service or payment for the service has been denied, reduced or terminated based on a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service, you have the right to have the decision reviewed by an independent review organization not associated with CIGNA.

Except where life or health would be seriously jeopardized, you must first exhaust the internal appeal process set forth in your plan documents before your request for an external independent review will be granted. If the plan does not strictly adhere to all internal claim and appeals processes, you can be deemed to have exhausted the internal appeal process.

Your appeal rights are outlined in your plan documents. In addition, before a final internal adverse benefit determination is issued, if applicable, you will be provided, free of charge,
any new or additional evidence considered, or rationale relied upon, in sufficient time to allow you the opportunity to respond before the final notice is issued.

Emergency Services
Emergency Services, as defined above, are covered without the need for any prior authorization determination and without regard as to whether the health care provider furnishing such services is a participating provider. Emergency Services, as defined above, provided by a Non-participating Provider will be covered as if the services were provided by a Participating Provider.

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. If your plan requires the designation of a primary care provider, CIGNA may designate one for you until you make this designation. 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.

Preexisting Condition Limitations
Any Preexisting Condition Limitation provision described in the plan document does not apply to anyone who is under 19 years of age.

Notice
Coverage of Dependent Children For Medical Benefits
Your Employer is not required to pay any portion of the premium for a Dependent child after the end of the calendar year in which the Dependent child reaches age 25. Your Employer will inform you of the applicable premium contribution required by you.

How To File Your Claim
The prompt filing of any required claim form will result in faster payment of your claim.
You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office. Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement
If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.
If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to CG.

Doctor's Bills and Other Medical Expenses
The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS
• BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.
  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
  YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
• PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.
WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.
Accident and Health Provisions

Claims

Notice of Claim
Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms
When CG receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss requirements of the policy if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss
Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination
CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Legal Actions
Where CG has followed the terms of the policy, no action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CG. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

Employee Insurance
This plan is offered to you as an Employee. To be insured, you will have to pay part of the cost.

Effective Date of Your Insurance
You will become insured on the date you elect the insurance by signing an approved payroll deduction form, but no earlier than the date you become eligible. If you are a Late Entrant, your insurance will not become effective until CG agrees to insure you. You will not be denied enrollment for Medical Insurance due to your health status. 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. However, you will not be insured for any loss of life, dismemberment or loss of income coverage until you are in Active Service.

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.
Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on 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.

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance will become insured for Medical Insurance on the date of his birth if you elect Dependent Medical 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.
## Open Access Plus Medical Benefits

### The Schedule

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

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

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

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

#### Out-of-Pocket Expenses
Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the benefit plan because of any:
- Coinsurance.
- Plan Deductibles.

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:
- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:
- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

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

#### Note:
Refer to your CIGNA Choice Fund Member Handbook for information about your health fund benefit and how it can help you pay for expenses that may not be covered under this plan.
## Open Access Plus Medical Benefits

### The Schedule

**Multiple Surgical Reduction**

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

**Assistant Surgeon and Co-Surgeon Charges**

**Assistant Surgeon**

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon’s allowable charge. (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 will be limited to 62.5 percent of the surgeon’s allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts).

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td></td>
<td>Unlimited</td>
</tr>
<tr>
<td>Coinsurance Levels</td>
<td>80%</td>
<td>60% of the Maximum Reimbursable Charge</td>
</tr>
</tbody>
</table>
## BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Maximum Reimbursable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Reimbursable Charge is determined based on the lesser of the provider’s normal charge for a similar service or supply; or A percentage of a schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider’s normal charge for a similar service or supply; or • the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company.</td>
</tr>
<tr>
<td>Note: The provider may bill you for the difference between the provider’s normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calendar Year Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
</tr>
<tr>
<td>Family Minimum</td>
</tr>
<tr>
<td>Family Maximum Calculation</td>
</tr>
<tr>
<td>Collective Deductible:</td>
</tr>
<tr>
<td>All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>110%</td>
</tr>
</tbody>
</table>

<p>| Individual | $1,250 per person | $2,500 per person |
| Family | $2,500 per family | $5,000 per family |</p>
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Combined Medical/Pharmacy Calendar Year Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined Medical/Pharmacy Deductible: includes retail and mail order drugs</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mail Order Pharmacy Costs Contribute to the Combined Medical/Pharmacy Deductible</td>
<td>Yes</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$5,000 per person</td>
<td>$5,000 per person</td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$10,000 per family</td>
<td>$10,000 per family</td>
</tr>
<tr>
<td>Family Maximum Calculation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Collective Out-of-Pocket Maximum:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All family members contribute towards the family Out-of-Pocket. An individual cannot have claims covered at 100% until the total family Out-of-Pocket has been satisfied.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Combined Medical/Pharmacy Out-of-Pocket Maximum</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Combined Medical/Pharmacy Out-of-Pocket: includes retail and mail order drugs</td>
<td>Yes</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Mail Order Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Physician’s Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office visit</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visits Consultant and Referral Physician’s Services</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Surgery Performed In the Physician’s Office</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Second Opinion Consultations (provided on a voluntary basis)</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Allergy Treatment/Injections</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Allergy Serum (dispensed by the Physician in the office)</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Preventive Care (children through age 15)</td>
<td>No charge</td>
<td>60%</td>
</tr>
<tr>
<td>Immunizations</td>
<td>No charge</td>
<td>60%</td>
</tr>
<tr>
<td>Routine Preventive Care (ages 16 and over)</td>
<td>No charge</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Immunizations</td>
<td>No charge</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Mammograms, PSA, PAP Smear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care Related Services (i.e. “routine” services)</td>
<td>No charge</td>
<td>60% 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>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>------------------------------------------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td><strong>Inpatient Hospital - Facility Services</strong></td>
<td><strong>80% after plan deductible</strong></td>
<td>60% after plan deductible</td>
</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 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 rate</td>
</tr>
<tr>
<td>Special Care Units (ICU/CCU)</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><strong>80% after plan deductible</strong></td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room</td>
<td>60% after plan deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Physician’s Visits/Consultations</strong></td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Professional Services</strong></td>
<td><strong>80% after plan deductible</strong></td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Surgeon</td>
<td>60% after plan deductible</td>
<td></td>
</tr>
<tr>
<td>Radiologist</td>
<td>60% after plan deductible</td>
<td></td>
</tr>
<tr>
<td>Pathologist</td>
<td>60% after plan deductible</td>
<td></td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td>60% after plan deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Professional Services</strong></td>
<td><strong>80% after plan deductible</strong></td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Surgeon</td>
<td>60% after plan deductible</td>
<td></td>
</tr>
<tr>
<td>Radiologist</td>
<td>60% after plan deductible</td>
<td></td>
</tr>
<tr>
<td>Pathologist</td>
<td>60% after plan deductible</td>
<td></td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td>60% after plan deductible</td>
<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
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<td>---------------------------------</td>
</tr>
<tr>
<td><strong>Emergency and Urgent Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Professional services (radiology, pathology and ER Physician)</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td>Urgent Care Facility or Outpatient Facility</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td>X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td>Independent x-ray and/or Lab Facility in conjunction with an ER visit</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td><strong>Inpatient Services at Other Health Care Facilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum: 60 days combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Laboratory and Radiology Services (includes pre-admission testing)</strong></td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Hospital Facility</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Independent X-ray and/or Lab Facility</td>
<td>100% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td><strong>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</strong></td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
</tbody>
</table>
## BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
</table>
| **Outpatient Short-Term Rehabilitative Therapy and Spinal Manipulation Services**  
  Calendar Year Maximum:  
  60 days for all therapies combined  
  Includes:  
  Physical Therapy  
  Speech Therapy  
  Occupational Therapy  
  Pulmonary Rehab  
  Cognitive Therapy  
  Spinal Manipulation Services  
  (includes Chiropractors) | 80% after plan deductible | 60% after plan deductible |
| **Outpatient Cardiac Rehabilitation**  
  Calendar Year Maximum:  
  36 days | 80% after plan deductible | 60% after plan deductible |
| **Home Health Care**  
  Calendar Year Maximum:  
  60 days (includes outpatient private nursing when approved as medically necessary) | 80% after plan deductible | 60% after plan deductible |
| **Hospice**  
  Inpatient Services  
  Outpatient Services  
  (same coinsurance level as Home Health Care) | 80% after plan deductible | 60% after plan deductible |
| **Bereavement Counseling**  
  Services provided as part of Hospice Care  
  Inpatient  
  Outpatient  
  Services provided by Mental Health Professional | 80% after plan deductible  
  80% after plan deductible | 60% after plan deductible  
  60% after plan deductible |
|                                            | Covered under Mental Health Benefit  
  Covered under Mental Health Benefit |
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternity Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Visit to Confirm Pregnancy</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>All subsequent Prenatal Visits,</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Postnatal Visits and Physician’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery Charges (i.e. global</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>maternity fee)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visits in addition</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>to the global maternity fee when</td>
<td></td>
<td></td>
</tr>
<tr>
<td>performed by an OB/GYN or Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery - Facility</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>(Inpatient Hospital, Birthing Center)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Abortion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes elective and non-elective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td><strong>Family Planning Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits, Lab and Radiology tests</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>and Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The standard benefit will include</td>
<td></td>
<td></td>
</tr>
<tr>
<td>coverage for contraceptive devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e.g. Depo-Provera and Intrauterine Devices)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diaphragms will also be covered when</td>
<td></td>
<td></td>
</tr>
<tr>
<td>services are provided in the physician’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>office.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Sterilization Procedure for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vasectomy/Tubal Ligation (excludes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reversals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
</tbody>
</table>
### Infertility Treatment

Services Not Covered include:

- Testing performed specifically to determine the cause of infertility.
- Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).
- Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).

**Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infertility Treatment</strong></td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Organ Transplants</strong></td>
<td><strong>Physician’s Office Visit</strong></td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td></td>
<td><strong>Inpatient Facility</strong></td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td></td>
<td><strong>Physician’s Services</strong></td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td></td>
<td><strong>Lifetime Travel Maximum:</strong> $10,000 per transplant</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td><strong>Calendar Year Maximum:</strong> Unlimited</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td><strong>External Prosthetic Appliances</strong></td>
<td><strong>Calendar Year Maximum:</strong> Unlimited</td>
<td>80% after plan deductible</td>
</tr>
</tbody>
</table>
**Nutritional Evaluation**

Calendar Year Maximum: 3 visits per person, however the three visit limit will not apply to treatment of diabetes.

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office Visit</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>80% after plan deductible</td>
<td>60% 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 sound, natural teeth.

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office Visit</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
</tbody>
</table>

**Routine Foot Disorders**

Not covered except for services associated with foot care for diabetes and peripheral vascular disease.

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not covered except for services</td>
<td>Not covered except for services</td>
</tr>
<tr>
<td></td>
<td>associated with foot care for</td>
<td>associated with foot care for</td>
</tr>
<tr>
<td></td>
<td>diabetes and peripheral</td>
<td>diabetes and peripheral</td>
</tr>
<tr>
<td></td>
<td>vascular disease.</td>
<td>vascular disease.</td>
</tr>
</tbody>
</table>

**Treatment Resulting From Life Threatening Emergencies**

Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.

**Mental Health**

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Outpatient (Includes Individual, Group and Intensive Outpatient)</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
</tbody>
</table>

**Substance Abuse**

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Outpatient (Includes Individual and Intensive Outpatient)</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>80% after plan deductible</td>
<td>60% after plan deductible</td>
</tr>
</tbody>
</table>
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;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for Mental Health or Substance Abuse Residential Treatment Services.

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

Covered Expenses incurred will be reduced by 50% for Hospital charges made for each separate admission to the Hospital:

- unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of admission.

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

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

Outpatient Certification Requirements - Out-of-Network

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

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

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

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

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Hysterectomy
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;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- outpatient facility services;
- intensive outpatient programs;
- advanced radiological imaging;
- nonemergency ambulance; or
- transplant services.

care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.

- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.

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

Covered Expenses
- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by an Ambulatory Surgical Center, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical services.
- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives; after appropriate counseling, medical services connected with surgical therapies, tubal ligations and vasectomies.
- office visits, tests and counseling for Family Planning services are subject to the Preventive Care Maximum shown in the Schedule.
- charges made for Routine Preventive Care from age 16 including immunizations, not to exceed the maximum shown in the Schedule. Routine Preventive Care means health care assessments, wellness visits and any related services.

- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: (a) a baseline mammogram for women ages 35 through 39; (b) a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; (c) a mammogram every year for women age 50 and over; and (d) one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician’s recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.

- charges for newborn and infant hearing screening and Medically Necessary follow-up evaluations. When ordered by the treating Physician, a newborn’s hearing screening must include auditory brainstem responses or evoked otacoustic emissions or other appropriate technology approved by the FDA. All screenings shall be conducted by a licensed audiologist, Physician, or supervised individual who has training specific to newborn hearing screening. Infant means an age range from 30 days through 12 months. Newborn means an age range from birth through 29 days.

- charges made for medical, surgical and Hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy. Services provided to you by a certified nurse-midwife or a licensed midwife, in a home setting or in a licensed birthing center. Coverage for a mother and her newborn child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. Post delivery care for a mother and her newborn shall be covered. Post delivery care includes: a postpartum assessment and newborn assessment, which can be provided at the hospital, the attending Physician’s office, and outpatient maternity center or in the home by an Other Health Care Professional trained in mother and newborn care. The services may include physical assessment of the newborn and mother, and the performance of any clinical tests and immunizations in keeping with prevailing medical standards.

- charges made for diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint. Appliances and non-surgical treatment including for orthodontia are not covered.

- coverage for diagnosis and treatment of autism spectrum disorder to include autistic disorder, Asperger's Syndrome and pervasive developmental disorder not otherwise specified, when prescribed by a treating Physician in accordance with a treatment plan for individuals diagnosed at age 8 or younger. Coverage is provided for Dependents to age 18, or older if attending High School. Treatment includes well-baby and well-child screening for diagnosis and treatment through speech therapy, occupational therapy, physical therapy and applied behavior analysis. Day or visit maximums applied to such treatment for other causes will not apply to treatment of autism spectrum disorder.

- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.

- charges for general anesthesia and hospitalization services for dental procedures for an individual who (a) is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or (b) has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.

- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.

- charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: (1) have vertebral abnormalities; (2) are receiving long-term glucocorticoid (steroid) therapy; (3) have primary hyperparathyroidism; (4) have a family history of
osteoporosis; and/or (5) are estrogen-deficient individuals who are at clinical risk for osteoporosis.

In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below, for a Dependent child who is age 15 or less, for charges made for Child Preventive Care Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

- a history;
- physical examination;
- development assessment;
- anticipatory guidance; and
- appropriate immunizations and laboratory tests;

excluding any charges for:

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

It is provided that any Deductible that would otherwise apply will be waived for those Covered Expenses incurred for Child Preventive Care Services. Approximate Age Intervals are: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years and 15 years.

charges for or in connection with a bone marrow transplant when recommended by a Physician and deemed acceptable by the appropriate oncological specialty. This treatment cannot be considered experimental under the rules of the Secretary of Health and Rehabilitative Services. Please call your Claims Office prior to receiving any treatment in order to determine your benefits.

charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be medically necessary by the Physician and in consultation with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.

orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not correct, provided:

- the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
- the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease or;
- the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

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

Clinical Trials

- charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:
  - the cancer clinical trial is listed on the NIH web site [www.clinicaltrials.gov](http://www.clinicaltrials.gov) as being sponsored by the federal government;
  - the trial investigates a treatment for terminal cancer and: (1) the person has failed standard therapies for the disease; (2) cannot tolerate standard therapies for the disease; or (3) no effective nonexperimental treatment for the disease exists;
  - the person meets all inclusion criteria for the clinical trial and is not treated “off-protocol”;
  - the trial is approved by the Institutional Review Board of the institution administering the treatment; and
  - coverage will not be extended to clinical trials conducted at nonparticipating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed herein as Exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Genetic Testing

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

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

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

Nutritional Evaluation

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

Internal Prosthetic/Medical Appliances

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

Home Health Services

- charges made for Home Health Services when you: (a) require skilled care; (b) are unable to obtain the required care as an ambulatory outpatient; and (c) do not require confinement in a Hospital or Other Health Care Facility. Home Health Services are provided only if CG has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others
for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

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

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
  - by-part-time or intermittent services of an Other Health Care Professional;

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

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

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

Mental Health and Substance Abuse Services

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

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

Inpatient Mental Health Services

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

Inpatient Mental Health services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions equal to one day of inpatient care.

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 services are exchanged with Inpatient Mental Health services at a rate of two days of Mental Health Residential Treatment services being equal to one day of Inpatient Mental Health Treatment.

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

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

Outpatient Mental Health Services

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

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

Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week. Mental Health Intensive Outpatient Therapy Program services are exchanged with Outpatient Mental Health services at a rate of one visit of Mental Health Intensive Outpatient Therapy being equal to one visit of Outpatient Mental Health Services.

**Inpatient Substance Abuse Rehabilitation Services**

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

Inpatient Substance Abuse services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions equal to one day of inpatient care.

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

Substance Abuse Residential Treatment services are exchanged with Inpatient Substance Abuse services at a rate of two days of Substance Abuse Residential Treatment being equal to one day of Inpatient Substance Abuse Treatment.

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

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

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program.
A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week. Substance Abuse Intensive Outpatient Therapy Program services are exchanged with Outpatient Substance Abuse services at a rate of one visit of Substance Abuse Intensive Outpatient Therapy being equal to one visit of Outpatient Substance Abuse Rehabilitation Services.

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

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

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Custodial care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.

- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

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

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

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

- **Bed Related Items**: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items**: bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices**: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- **Fixtures to Real Property**: ceiling lifts and wheelchair ramps.
- **Car/Van Modifications**.
- **Air Quality Items**: room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items**: blood pressure cuffs, centrifuges, nova pens and needleless injectors.
• **Other Equipment**: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

• 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.

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**External Prosthetic Appliances and Devices**

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

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

**Prostheses/Prosthetic Appliances and Devices**

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

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

**Orthoses and Orthotic Devices**

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

• Nonfoot orthoses – only the following nonfoot orthoses are covered:
  • rigid and semirigid custom fabricated orthoses,
  • semirigid prefabricated and flexible orthoses; and
  • rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.

• Custom foot orthoses – custom foot orthoses are only covered as follows:
  • for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  • when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;

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

**Braces**

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

The following braces are specifically excluded: Copes scoliosis braces.

**Splints**

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts. Coverage for replacement of external prosthetic appliances and devices is limited to the following:

• Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
• Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
• Coverage for replacement is limited as follows:
  • No more than once every 24 months for persons 19 years of age and older and
• No more than once every 12 months for persons 18 years of age and under.
• Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:
• External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
• Myoelectric prostheses peripheral nerve stimulators.

The following are specifically excluded from Spinal Manipulation Services:
• services of a chiropractor which are not within his scope of practice, as defined by state law;
• charges for care not provided in an office setting;
• vitamin therapy.

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

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

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

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

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

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

- travel costs incurred due to travel within 60 miles of your home;
- laundry bills;
- telephone bills;
- alcohol or tobacco products;
- and charges for transportation that exceed coach class rates.

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

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

Reconstructive Surgery
- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or (c)

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by CG only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CG within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled to Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- You have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- Your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance; or the policy canceled.
- You are not eligible for Medicare.
- You would not be Overinsured.

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents, if you are not Entitled to Convert solely because you are eligible for Medicare;
but only if that Dependent: (a) was insured when your insurance ceased; (b) is not eligible for Medicare; and (c) would not be Overinsured.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- His insurance under this plan is replaced by similar group coverage within 31 days.
- The benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on CG's underwriting standards for individual policies. Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; (b) those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of CG's current offerings at the time the first premium is received based on its rules for Converted Policies. It will comply with the laws of the jurisdiction where the group medical policy is issued. However, if the applicant for the Converted Policy resides elsewhere, the Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where he resides. The Converted Policy offering may include medical benefits on a group basis. The Converted Policy need not provide major medical coverage unless it is required by the laws of the jurisdiction in which the Converted Policy is issued.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan.

CG or the Policyholder will give you, on request, further details of the Converted Policy.
Prescription Drug Benefits

The Schedule

For You and Your Dependents

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

Certain retail Participating Pharmacies can fill your prescription for a 90 day supply for an amount equal to 3x the retail Participating Pharmacy Copayment. Please see our website at www.CIGNA.com or call the Member Services number on your ID card for a list of retail Participating Pharmacies that offer the 3x retail Participating Pharmacy Copayment level.

Coinsurance

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

Charges

The term Charges means the amount charged by the Insurance Company to the plan when the Pharmacy is a Participating Pharmacy.

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>PARTICIPATING PHARMACY</th>
<th>Non-PARTICIPATING PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td>Refer to the Medical Benefits Schedule</td>
<td>Refer to the Medical Benefits Schedule</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>Refer to the Medical Benefits Schedule</td>
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</tr>
<tr>
<td>Individual</td>
<td>Refer to the Medical Benefits Schedule</td>
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</tr>
<tr>
<td>Family</td>
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<td>Refer to the Medical Benefits Schedule</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>Refer to the Medical Benefits Schedule</td>
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</tr>
<tr>
<td>Retail Prescription Drugs</td>
<td>The amount you pay for each 30-day supply</td>
<td>The amount you pay for each 30-day supply</td>
</tr>
<tr>
<td>Tier 1</td>
<td>Generic* drugs on the Prescription Drug List</td>
<td>30% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>In-network coverage only</td>
<td></td>
</tr>
</tbody>
</table>

*Generic*
## BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Tier 2</th>
<th>PARTICIPATING PHARMACY</th>
<th>Non-PARTICIPATING PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent</td>
<td>40% after plan deductible</td>
<td>In-network coverage only</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 3</th>
<th>PARTICIPATING PHARMACY</th>
<th>Non-PARTICIPATING PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List</td>
<td>50% after plan deductible</td>
<td>In-network coverage only</td>
</tr>
</tbody>
</table>

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

### Mail-Order Drugs

<table>
<thead>
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<th>The amount you pay for each 90-day supply</th>
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</tbody>
</table>

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

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

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

Limitations
Each Prescription Order or refill shall be limited as follows:
• up to a consecutive 30-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging; or
• up to a consecutive 90-day supply at a mail-order Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
• to a dosage and/or dispensing limit as determined by the P&T Committee.

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

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

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

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

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P & T Committee clinically evaluates the Prescription Drug for a different designation.

Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

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

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
- any drugs that are experimental or investigational as described under the Medical "Exclusions" section of your certificate;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- any fertility drug;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmia, and decreased libido;
- prescription vitamins (other than prenatal vitamins), pediatric multivitamins containing fluoride, and dietary supplements; dietary supplements, and fluoride products;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue.

Other limitations are shown in the Medical "Exclusions" section.

Reimbursement/Filing a Claim

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

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

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

Exclusions, Expenses Not Covered and General Limitations

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

- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
to the extent that payment is unlawful where the person resides when the expenses are incurred.

charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government: (a) unless there is a legal obligation to pay such charges whether or not there is insurance; or (b) if such charges are directly related to a military-service-connected Injury or Sickness.

for or in connection with an Injury or Sickness which is due to war, declared or undeclared.

charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.

assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

for or in connection with experimental, investigational or unproven services.

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

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

cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.

regardless of clinical indication for macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniomaxillofacial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by an Ambulatory Surgical Center or the outpatient department of a Hospital in connection with surgery.

for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.

court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.

infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.

reversal of male or female voluntary sterilization procedures.

transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.

medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.

nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training,
educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, or mental retardation.

- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.

- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.

- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.

- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.

- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.

- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.

- charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.

- treatment by acupuncture.

- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.

- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

- dental implants for any condition.

- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

- blood administration for the purpose of general improvement in physical condition.

- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.

- cosmetics, dietary supplements and health and beauty aids.

- nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.

- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.

- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.

- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.

- telephone, e-mail, and Internet consultations, and telemedicine.

- massage therapy.

- for charges which would not have been made if the person had no insurance.

- to the extent that they are more than Maximum Reimbursable Charges.

- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident.
and the charges are incurred while traveling on business or for pleasure.

- charges made by any covered provider who is a member of your family or your Dependent’s family.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

Pre-existing Condition Limitations
No payment will be made for Covered Expenses for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-existing Condition
A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person begins an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-existing Condition Limitation
Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered within 31 days of birth, adoption or placement for adoption. Such waiver will not apply if 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage Under Prior Plan
If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy.

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

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

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

1. 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.

2. Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.

3. Medical benefits coverage of group, group-type, and individual automobile contracts.

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

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

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

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

Allowable Expense
A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable
Cash Value of each service is the Allowable Expense and is a paid benefit.

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

(1) 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.

(2) 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.

(3) 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.

(4) 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.

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

Claim Determination Period

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

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:

(1) 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;

(2) 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;

(3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
   (a) 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;
   (b) then, the Plan of the parent with custody of the child;
   (c) then, the Plan of the spouse of the parent with custody of the child;
   (d) then, the Plan of the parent not having custody of the child, and
   (e) finally, the Plan of the spouse of the parent not having custody of the child.

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.
a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

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

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

**Effect on the Benefits of This Plan**

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

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

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

(1) CG's obligation to provide services and supplies under this policy;

(2) whether a benefit reserve has been recorded for you; and

(3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

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

**Recovery of Excess Benefits**

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

CG 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**

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

**Medicare Eligibles**

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

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

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

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

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;
(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

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

CG will assume the amount payable under:

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

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

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

**Domestic Partners**

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan. Therefore, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and CIGNA is the Secondary Plan.

**Expenses For Which A Third Party May Be Liable**

This policy does not cover expenses for which another party may be responsible as a result of having caused or contributed to the Injury or Sickness. If you incur a Covered Expense for which, in the opinion of CG, another party may be liable:

1. CG shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Policy. You or your representative shall execute such documents as may be required to secure CG's subrogation rights.

2. Alternatively, CG may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to CG the lesser of:
   - a. the amount actually paid for such Covered Expenses by CG; or
   - b. the amount you actually receive from the third party for such Covered Expenses;

   at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or award or otherwise.

**Payment of Benefits**

**To Whom Payable**

All Medical Benefits are payable to you. However, at the option of CG, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical Benefits are not assignable unless agreed to by CG. CG may, at its option, make payment to you for the cost of
any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of CG, 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, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executives or administrators of your estate.

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

**Time of Payment**

Benefits will be paid by CG when it receives due proof of loss.

**Recovery of Overpayment**

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

**Calculation of Covered Expenses**

CG, 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.

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: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

**Injury or Sickness**

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

**Termination of Insurance**

**Employees**

Your insurance will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.
- The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

**Dependents**

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

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

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

**Special Continuation of Medical Insurance for Dependents of Military Reservists**

If your insurance ceases because you are called to active military duty in: (a) the Florida National Guard; or (b) the United States military reserves, you may elect to continue Dependent insurance. You must pay the required premiums to the Policyholder if you choose to continue Dependent insurance. In no event will coverage be continued beyond the earliest of the following dates:

- the expiration of 30 days from the date the Employee's military service ends;
- the last day for which the required contribution for Dependent insurance has been made;
Medical Benefits Extension

Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury, Sickness or pregnancy, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury, Sickness or pregnancy. 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 a succeeding carrier agrees to provide coverage without limitation for the disabling condition;
- the date you are no longer Totally Disabled;
- 12 months from the date the policy is canceled; or
- for pregnancy, until delivery.

Totally Disabled

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

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

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

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

Federal Requirements

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

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

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

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

Qualified Medical Child Support Order (QMCSO)

A. 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.

B. 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:

1. the order recognizes or creates a child’s right to receive group health benefits for which a participant or beneficiary is eligible;
2. 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;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. 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.

C. 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 Dependents of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.
• 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: (a) due to failure of the employer or other responsible entity to remit premiums on a timely basis; (b) 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 (c) when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer’s limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

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

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption.

Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Individuals who enroll in the Plan due to a special enrollment event will not be considered Late Entrants. Any Pre-existing Condition limitation will be applied upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

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

Coverage of Students on Medically Necessary Leave of Absence

(Appplies to Students Age 26 or Over When Covered Under This Plan)

If your Dependent child is covered by this plan as a student, as defined in the Definition of Dependent, coverage will remain active for that child if the child is on a medically necessary
leave of absence from a postsecondary educational institution (such as a college, university or trade school.)

Coverage will terminate on the earlier of:

- The date that is one year after the first day of the medically necessary leave of absence; or
- The date on which coverage would otherwise terminate under the terms of the plan.

The child must be a Dependent under the terms of the plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence.

The plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

A “medically necessary leave of absence” is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that:

starts while the child is suffering from a serious illness or condition; is medically necessary; and causes the child to lose student status under the terms of the plan.

Effect of Section 125 Tax Regulations on This Plan

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

A. Coverage Elections

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

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

B. Change of Status

A change in status is defined as:

1. change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;

2. change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;

3. 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;

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

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

6. 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: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage or open enrollment periods.
Eligibility for Coverage for Adopted Children
Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child’s adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the “Exception for Newborns” section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Coverage for Maternity Hospital Stay
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.

Pre-Existing Conditions Under the Health Insurance Portability & Accountability Act (HIPAA)
(Not Applicable To Anyone Under 19)
A federal law known as the Health Insurance Portability & Accountability Act (HIPAA) establishes requirements for Pre-existing Condition limitation provisions in health plans. Following is an explanation of the requirements and limitations under this law.

A. Pre-Existing Condition Limitation
Under HIPAA, a Pre-existing Condition limitation is a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under the plan, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. A Pre-existing Condition limitation is permitted under group health plans, provided it is applied only to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period (or a shorter period as applies under the plan) ending on the enrollment date. Plan provisions may vary. Please refer to the section entitled “Exclusions, Expenses Not Covered and General Limitations” for the specific Pre-existing Condition limitation provision which applies under this Plan, if any.
B. Exceptions to Pre-existing Condition Limitation

Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

An adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered under any Creditable Coverage within 30 days of adoption or placement for adoption. Such waiver will not apply if 63 days or more elapse between coverage under the prior Creditable Coverage and coverage under this Plan.

C. Credit for Coverage Under Prior Plan

If you and/or your Dependent(s) were previously covered under a plan which qualifies as Creditable Coverage, CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under the prior plan(s). However, credit is available only if you notify the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this Plan, exclusive of any waiting period. Credit will be given for coverage under all prior Creditable Coverage, provided fewer than 63 days elapsed between coverage under any two plans.

If you and/or your Dependent enrolled or re-enrolled in COBRA continuation coverage or state continuation coverage under the extended election period allowed in the American Recovery and Reinvestment Act of 2009 (“ARRA”), this lapse in coverage will be disregarded for the purposes of determining Creditable Coverage.

D. Certificate of Prior Creditable Coverage

You must provide proof of your prior Creditable Coverage in order to reduce a Pre-Existing Condition limitation period. You should submit proof of prior coverage with your enrollment material. A certificate of prior Creditable Coverage, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent directly to: Eligibility Production Services, 900 Cottage Grove Road, Routing C2ECC, Hartford, CT 06152. You should contact the Plan Administrator or call 1-800-244-6224.

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call 1-800-CIGNA24 or 1-800-244-6224.

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

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) 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:

A. 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.

B. 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 or the requirements of any Pre-existing Condition limitation 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.

A. Continuation of Coverage

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

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

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

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

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

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

B. Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) 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 Pre-Existing Condition Limitation (PCL) or 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.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

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.

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

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

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

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.
Who is Entitled to COBRA Continuation?

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

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, 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:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. 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: (a) the end of the applicable maximum period; (b) the date the pre-existing condition...
provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or

• any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer’s Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Employer’s service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer’s service area. If the Employer offers another benefit option through CIGNA or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer’s Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

• An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse’s) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.

• A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:

  (a) 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;

  (b) 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

  (c) 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;
- Your child ceases to qualify as a Dependent under the Plan; or
- 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.

**Trade Act of 2002**

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cfm.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed...
under “Termination of COBRA Continuation” above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

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

Interaction With Other Continuation Benefits
You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

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

The Following Will Apply To Residents of Florida

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

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

Start with Member Services
We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

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

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

Appeals Procedure
CG has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. 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 or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

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

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond 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.

You may request that the appeal process be expedited if, (a) 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 (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.
Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee 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 Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) 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 (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

If you are not fully satisfied with the decision of CG's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CG's level two appeal review denial. CG will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by CG's Physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by CG.

Appeal to the State of Florida

You have the right to contact the state regulators for assistance at any time. The state regulators may be contacted at the following addresses and telephone numbers:

- **The Statewide Provider and Subscriber Assistance Panel**
  - Fort Knox Building One, Room 303
  - 2727 Mahan Drive
  - Tallahassee, FL 32308
  - 1-888-419-3456 or 850-921-5458

- **The Agency for Health Care Administration**
  - Fort Knox Building One, Room 303
  - 2727 Mahan Drive
  - Tallahassee, FL 32308
  - 1-888-419-3456

- **The Department of Insurance**
  - State Treasurer's Office
  - State Capitol, Plaza Level Eleven
  - Tallahassee, FL 32308
  - 1-800-342-2762

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) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) 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; (4) 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); (5) 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.

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

Relevant Information
Relevant Information is any document, record, or other information which (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 CG 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 on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
• on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

Ambulatory Surgical Center
The term Ambulatory Surgical Center means a licensed institution which:
• is run by Physicians;
• has a staff that includes Registered Graduate Nurses;
• has a permanent place equipped for performing Surgical Procedures; and
• gives continuous Physician services on an outpatient basis.

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

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

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: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

**Dependent - For Medical Insurance**

Dependents are:

- your lawful spouse; and
- any child of yours:
  - who is less than 19 years old;
  - from 19 years of age until the end of the calendar year in which the child reaches age 25, provided the child is both primarily supported by you and either living in your household or enrolled as a full-time or part-time student. CG may require such proof at least once each year until the end of the calendar year in which he attains age 25;
  - from the end of the calendar year in which the child reaches 25 years until the end of the calendar year in which the child reaches the age of 30, provided the child is unmarried and does not have a dependent of their own, is a Florida state resident or a full-time or part-time student, and is not covered under a plan of their own or entitled to benefits under Title XVIII of the Social Security Act. CG may require such proof at least once each year until the end of the calendar year in which he attains age 30;
  - who is 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence is not required to be submitted to CG as a condition of coverage after the date the child ceases to qualify above. However, if a claim is denied, proof must be submitted by the Employee that the child is and has continued to be mentally or physically handicapped.

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. A child also includes a foster child or a child placed in your custody by a court order from the date of placement in the home. Coverage is not required if the adopted or foster child is ultimately not placed in your home. It also includes:

- a stepchild who lives with you, or a child for whom you are the legal guardian;
- a child born to an insured Dependent child of yours until such child is 18 months old.

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

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

**Emergency Services**

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

**Employee**

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does
not include employees who are part-time or temporary or who normally work less than 37.5 hours a week for the Employer.

**Employer**
The term Employer means the Policyholder and all Affiliated Employers.

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

**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) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) 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 CG; 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: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) 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 Hospitals, the American Osteopathic Hospital Association, or the Commission on the Accreditation of Rehabilitative Facilities;
- an institution which: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency;
- an Ambulatory Surgical Center; or
- a licensed birthing center.
The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

**Hospital Confinement or Confined in a Hospital**
A person will be considered Confined in a Hospital if he is:
- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.
Injury
The term Injury means an accidental bodily injury.

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

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

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

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

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

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

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

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

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

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

**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.

**Participating Pharmacy**
The term Participating Pharmacy means a retail pharmacy with which Connecticut General Life Insurance Company has contracted to provide prescription services to insureds; or a designated mail-order pharmacy with which CG has contracted to provide mail-order prescription services to insureds.

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

**Pharmacy**
The term Pharmacy means a retail pharmacy, or a mail-order pharmacy.

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

**Physician**
The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:
- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

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

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

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

DFS1711

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

DFS622

**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.

DFS170

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

DFS1710

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

DFS1688

**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.

DFS531

**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: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DFS193

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

DFS197

**Urgent Care**
Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by CG, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the
immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.
The following pages describe the features of your CIGNA Choice Fund - Health Savings Account. Please read them carefully.
What You Should Know about CIGNA Choice Fund® — Health Savings Account

CIGNA Choice Fund is designed to give you more of what you want:
- Options to help you manage your health and your health care
- Simple ways to predict and track cost
- A better understanding of your options

What’s in it for you?

Control
The services you get and where you get them are up to you.

Choice
You have the freedom to choose any licensed doctor, even those who do not participate with CIGNA HealthCare. Your costs are lower for services from CIGNA contracted providers.

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

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

Easy Access to your HSA Dollars
You can draw money directly from your health savings account using the JPMorgan Chase/MasterCard® debit card or checkbook. Or, you may choose automatic claim forwarding, which allows CIGNA to pay your qualified medical claims directly from your account to your doctor or hospital.

Tools
Easy-to-use resources help you make informed decisions.

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

Support
We help you keep track with online benefits information, transactions, and account activity; medical and drug cost comparisons; monthly statements; and more. You also have toll-free access to dedicated Member Service teams, specially trained to answer your questions and address your needs.

Savings on Health and Wellness Products and Services
Through CIGNA Healthy Rewards®, you can save money on products and services not often covered by many traditional plans. Offerings include laser vision correction, acupuncture, chiropractic care, Weight Watchers®, and more.

Opportunity to earn funds for future use
If your employer offers Through the CIGNA Healthy Future Account®, you may have accumulated unused funds from your Health Reimbursement Arrangement. Once you meet the eligibility requirements (such as retirement, reaching age 65, or accumulating a certain number of years of service with your employer), you may then use the Healthy Future Account to pay yourself back for certain dental and vision expenses. For more information, please visit myCIGNA.com. See your benefits administrator for more details.

The Basics
Who is eligible?
You are eligible to open a Health Savings Account only if you are covered under a federally qualified high deductible health plan, such as the one described in this booklet. However, you cannot be covered by Medicare or any other individual or group health plan that is not a federally qualified high deductible health plan. You or your spouse also cannot have a health care Flexible Spending Account (FSA) unless it is a limited purpose FSA which limits reimbursement to only dental, vision and preventive care expenses. You can no longer contribute to the HSA once you: become entitled to Medicare due to age; or are no longer covered under a high deductible health plan. However, you will still be able to use the HSA funds for qualified medical expenses.

How does it work?
The Health Savings Account combines traditional medical coverage with a savings account.

1. You and your employer may contribute. Contributions are tax-free up to federal limits.

2. You choose how to pay for qualified medical expenses:
   - You may pay claims on your own using a debit card or checkbook that draws from your savings account.
   - You may choose the Automatic Claim Forwarding option, allowing claims to be paid directly to your doctor, hospital, or other facility. So you don’t have to do a thing – your claims are paid automatically while
there is money in your savings account. (You can change your election at any time during the year.)

- You may choose to cover your expenses using your own personal funds. This allows you to save your HSA dollars for qualified medical expenses in future years or at retirement. The balance in your savings account will earn interest.

Regardless of how you choose to pay for qualified medical expenses, the next step is to meet the deductible. Only covered services count toward the deductible.

3. **Once your deductible is met, you use a traditional medical plan for covered services.** Depending on your plan, you pay pre-determined coinsurance or copayments for certain services. Your employer determines the maximum amount of out-of-pocket expenses you pay each year.

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

HSA funds can be used to cover only qualified medical expenses for you and your dependents as allowed under federal tax law. In addition, HSA funds can be used to cover COBRA continuation premiums, qualified long-term care insurance premiums, health plan premiums when you are receiving unemployment compensation, Medicare or retiree health plan premiums (excluding Medicare Supplement or Medigap premiums) once you reach age 65. If you use your HSA funds for expenses that are not allowed under federal tax law, the contributions to your HSA fund and any accrued interest and earnings will be subject to tax, and you will incur a 10 percent tax penalty. The 10 percent penalty is not applicable once you reach age 65. A list of qualified medical expenses is available on CIGNA.com.

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

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

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

If all of your medical expenses are covered services and the total cost doesn’t exceed the amount in your savings account, you won’t have additional out-of-pocket costs.

Your plan may also include a Flexible Spending Account (FSA). If you are eligible to enroll in this account, you can contribute pre-tax dollars from each paycheck — then use the funds to reimburse yourself for qualified medical expenses. Before you meet your medical plan deductible, FSAs can be used only for qualified dental, vision and preventive care expenses, if your employer allows. After you meet the medical plan deductible, the FSA can reimburse qualified medical expenses as well as other over-the-counter pharmacy, vision and other expenses as determined by your employer. In addition, your employer may allow you to use FSA funds remaining at the end of the plan year to pay for claims incurred during the 2½ months after your plan year ends. Please check with your employer to determine if this option is available to you.

### Suspended HRA (if offered by your employer)

Your plan may also include a Suspended Health Reimbursement Arrangement (HRA). You are eligible to participate in the Suspended HRA if you were previously enrolled in a CIGNA Choice Fund General Medical HRA, and then enrolled in the CIGNA Choice Fund Health Savings Account. If there are unused dollars in your General Medical HRA, you can spend these dollars for qualified expenses as determined by your employer. For more information, please contact your benefits administrator.

### Are services covered if I use out-of-network doctors?

You can use the dollars in your HSA to visit any licensed doctor or facility. However, if you choose a provider who participates with CIGNA HealthCare, your costs will be lower.

### Key Terms

**Deductible**

The amount that you must pay for covered medical expenses before the underlying health plan covers expenses.

**Collective Deductible:**

If you have family coverage, you must pay all costs up to the family deductible before you use the medical plan for covered services, even if qualified expenses for one person meet your plan’s individual deductible.

**For example:** Suppose your plan has an individual deductible of $1,500 and a family deductible of $3,000. If you pay $1,500 in qualified medical expenses for one person, you still do not meet your deductible until qualified costs from any individual or all covered persons total $3,000.

**Maximum Savings Account Amount**

The maximum amount of money you may have in your HSA.

**Plan Coinsurance**

The percentage of charges you pay for expenses covered by your traditional medical plan.
Tools and Resources at Your Fingertips

myCIGNA.com

To help you understand your benefits, we’ve created a suite of information and tools that you can access confidentially through our member website myCIGNA.com.

You have a right to know the cost of services you receive. You have the power to make a difference in the type and quality of those services. You have unique health care needs.

And that’s why you have myCIGNA.com – to find value in your health plan. myCIGNA.com includes helpful resources specifically for members who have CIGNA Choice Fund.

- Online access to your current fund balance, past transactions and claim status.
- Your own savings account calculator, with account balance tracking and transaction worksheets to estimate your out-of-pocket expenses.
- Medical cost and drug cost information, including average costs for your state.
- Explanations of other CIGNA HealthCare products and services – what they are and how you can use them.
- Frequently asked questions – about health care in general and CIGNA HealthCare specifically.
- A number of convenient, helpful tools that let you:
  
  **Compare costs**

  Use tools to compare costs and help you decide where to get care. You can get average price ranges for certain ambulatory surgical procedures and radiology services. You can also find estimated costs in your region for common medical services and conditions.

  **Find out more about your local hospitals**

  Learn how hospitals rank by number of procedures performed, patients’ average length of stay, and cost. Go to our online provider directory for estimated average cost ranges for certain procedures, including total charges and your out-of-pocket expense, based on a CIGNA HealthCare benefit plan. You can also find hospitals that earn the “Centers of Excellence” designation based on effectiveness in treating selected procedures/conditions and cost.

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

  Use the pharmacy tools to: check your prescription drug costs, listed by specific pharmacy and location (including CIGNA Tel-Drug®); and review your claims history for the past 16 months. Click “WebMD Drug Comparison Tool” under Related Health Resources to look at condition-specific drug treatments and compare characteristics of more than 200 common medications. Evaluate up to 10 medications at once to better understand side effects, drug interactions and alternatives.

  **Take control of your health**

  Take the health risk assessment, an online questionnaire that can help you identify and monitor your health status. You also can find out how your family history may affect you, learn about preventive care and check your progress toward healthy goals. And if your results show that you may benefit from other services, you can learn about related CIGNA HealthCare programs on the same site.

  **Explore topic on medicine, health and wellness**

  Get information on more than 5,000 health conditions, health and wellness, first aid and medical exams through Healthwise®, an interactive library. Research articles on clinical findings through Condition Centers®.

  **Keep track of your personal health information**

  Health Record is your central, secure location for your medical conditions, medications, allergies, surgeries, immunizations, and emergency contacts. You can add your health risk assessment results to Health Record, so you can easily print and share the information with your doctor.

  Your lab results from certain facilities can be automatically entered into your Personal Health Record.

  **Chart progress of important health indicators**

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

  **CIGNA Health Advisor®/Personal Health Team**

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

  **Getting the Most from Your HSA**

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

myCIGNA.com
Fast Facts

If you visit a CIGNA HealthCare participating provider, the cost is based on discounted rates, so your costs will be lower. If you visit a provider not in the network, you may still use CIGNA Choice Fund to pay for the cost of those services, but typically you will pay a higher rate, and you may have to file claims.

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

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

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

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

A little knowledge goes a long way.

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

- Getting appropriate preventive care is key to staying healthy. Your CIGNA HealthCare participating doctor can provide a wide variety of tests and exams that are covered by your CIGNA HealthCare plan. Visit myCIGNA.com to learn more about proper preventive care and what’s covered under your plan. You can also find ways to stay healthy by calling the CIGNA HealthCare 24-Hour Health Information Line, which includes audio tapes on preventive health, exercise and fitness, nutrition and weight control, and more.

  - When it comes to medications, talk to your doctor about whether generic drugs are right for you. The brand-name drugs you are prescribed may have generic alternatives that could lower your costs. If a generic version of your brand-name drug is not available, other generic drugs with the same treatment effect may meet your needs.
  - The health care cost estimator tool on myCIGNA.com can help you use the plan effectively. When planning and budgeting, consider:
    - Your medical and prescription drug expenses from last year.
    - Any expected changes in your medical spending in the coming year.
    - Your anticipated benefit expenses and out-of-pocket costs for the coming year.
    - The amount in your CIGNA Choice Fund compared with your expected out-of-pocket costs. Keep in mind the copayment and/or coinsurance you will pay once the fund is spent.
  - Additional tools on myCIGNA.com can help you take control of your health, learn more about medical topics and wellness, and keep track of your personal health information. You can print personalized reports to discuss with your doctor.

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

Please note: Your HSA contributions are not taxable under federal and most state laws. However, your contributions to your HSA may be taxable as income in the following states: Alabama, California, New Jersey, and Wisconsin. If you live or work in one of these states, please consult your tax advisor.