

**JPMorgan Chase & Co.**

PREFERRED PROVIDER MEDICAL  
BENEFITS  
HAWAII Plan

**EFFECTIVE DATE: January 1, 2020**

CN003  
3174696

This document printed in July, 2020 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.



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*Home Office: Bloomfield, Connecticut  
Mailing Address: Hartford, Connecticut 06152*

**CIGNA HEALTH AND LIFE INSURANCE COMPANY**

a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

**POLICYHOLDER: JPMorgan Chase & Co.**

**GROUP POLICY(S) — COVERAGE**

3174696 - HAWAII PREFERRED PROVIDER MEDICAL BENEFITS

**EFFECTIVE DATE:** January 1, 2020

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.

  
*Anna Krishtul, 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.

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## Case Management

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

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

- You, your dependent or an attending Physician can request Case Management services by calling the **toll-free number** shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

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

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## Additional Programs

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



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

### **CIGNA HEALTHY REWARDS® PROGRAM**

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

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

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

Discounts are available for these health and wellness programs:

#### **Fitness**

- Fitness Club (American Specialty Health ("ASH"))
- Just Walk 10,000 Steps-a-Day™

#### **Weight Management and Nutrition**

- Healthyroads® Weight Management (ASH)
- Registered Dietitian Network (ASH)
- Jenny Craig®

#### **Vision and Hearing Care**

- Exams and Eyewear
- Lasik Vision Correction
- Hearing Exams and Aids (Amplifon®)

#### **Tobacco Cessation**

- Healthyroads® Tobacco Cessation (ASH)

#### **Alternative Medicine/Alternative Medicine (ASH)**

- Acupuncture
- Chiropractic
- Massage Therapy

#### **Mind/Body**

- Healthyroads® Mind/Body (ASH)
- Gaiam® Yoga equipment discounts

#### **Vitamins, Health & Wellness Products**

- Drugstore.com™

- ChooseHealthy® - Discounts on natural supplements (ASH)

**Not all Healthy Rewards programs are available in all states. For complete information on Healthy Rewards, please visit [myCigna.com](http://myCigna.com) and go to the My Health page, or call 1.800.870.3470.**

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## **Important Notices**

### **Direct Access to Obstetricians and Gynecologists**

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

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## **Important Information**

### **Mental Health Parity and Addiction Equity Act**

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

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

### **The Schedule and Mental Health and Substance Abuse Covered Expenses:**

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

#### **Mental Health and Substance Abuse Services**

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



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

#### **Inpatient Mental Health Services**

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

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

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

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

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

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

#### **Inpatient Substance Abuse Rehabilitation Services**

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the

diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Residential Treatment services.

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

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

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

#### **Outpatient Substance Abuse Rehabilitation Services**

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

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

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

#### **Substance Abuse Detoxification Services**

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

#### **Mental Health and Substance Abuse Exclusions:**

The following exclusion is hereby deleted and no longer applies:

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

**Terms within the agreement:**

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

**Visit Limits:**

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

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**Discrimination is Against the Law**

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

Cigna:

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

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

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

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

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

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

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

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**Proficiency of Language Assistance Services**

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

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

**Chinese** – 注意：我們可為您免費提供語言協助服務。

對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。

其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

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

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

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

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

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

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

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

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

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

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

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

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

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

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## Prior Authorization

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

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

### Agents to Treat Multiple Sclerosis

Avonex  
Betaseron  
Copaxone  
Rebif

**Antineoplastic LHRH (GnRH) Agonist, Pituitary Suppr.**  
Lupron  
Zoladex

### Aminoglycosides

Garamycin  
Nebcin  
Tobramycin Sulfate

**Antineoplastic Systemic Enzyme Inhibitors**  
Gleevec  
Iressa  
Nexavar  
Tarceva

### Analgesics, Narcotics

Actiq

**Antiparkinsonism Drugs, Other**  
Apokyn

### Androgenic Agents

Delatestryl  
Depo-Testosterone  
Testosterone Propionate

**Antipsoriatics Agents, Systemic**  
Raptiva

**Anti-Inflammatory, Tumor Necrosis Factor Inhibitor**  
Enbrel

**Antivirals, HIV- Specific, Fusion Inhibitor**  
Fuzeon

**Anti-Inflammatory, Interleukin - 1 Receptor Antagonist**  
Kineret

**Bone Formation Stim. Agent**  
Forteo  
Miacalcin

<b>Anti-Inflammatory, Pyrimid Synthesis Inhibitor</b> Arava	<b>Cephalosporins - 3rd Generation</b> Rocephin	<b>Insulin-like Growth Hormone</b> Increlex	<b>Pulm.Anti-HTN, Sel. C-GMP Phosphodiesterase T5 Inhibitor</b> Revatio
<b>Anti-Inflammatory, Tumor Necrosis Factor Inhibitor</b> Humira	<b>Drugs to Treat Impotency</b> Caverject Cialis Edex Levitra Muse Viagra	<b>Leukocyte (WBC) Stimulants</b> Leukine Neulasta Neupogen	<b>Somatostatic Agents</b> Octreotide Acetate Sandostatin Penlac Panretin
<b>Antiemetic/Antivertigo Agents</b> Anzemet Kytril Zofran Vfend	<b>Drugs To Treat Chronic Inflamm. Disease</b> Remicade	<b>LHEH (GNRH) Agnst Pit. Sup-Central Precocious Puberty</b> Lupron Depot	<b>Vitamin A Derivatives</b> Tretinoin Differin Avita Retin-A Retin-A Micro Tretin-X
<b>Antimalarial Drugs</b> Lariam Malarone	<b>Gold Salts</b> Myochrysine	<b>LHRH (GNRH) Agonist Analog Pituitary Suppressants</b> Supprelin	<b>Cardiovascular - Cholesterol Lowering</b> Altoprev Crestor Livalo Mevacor Pravachol Zocor
<b>Growth Hormone</b> Genotropin Humatrope Norditropin Nutropin Saizen Serostim Tev-Tropin Zorbtive	<b>NSAIDS, Cyclooxygenase Inhibitor</b> Celebrex Ketorolac Tromethamine Toradol	<b>Monoclonal Antibodies to Immunoglobulin E(GE)</b> Xolair Pulmozyme	
<b>Growth Hormone Receptor Antagonist</b> Somavert	<b>Oxazolidinones</b> Zyvox		
<b>Hematinics, other</b> Aranesp Epogen Procrit	<b>Platelet Proliferation Stimulants</b> Neumega		
<b>Hepatitis C Treatment Agents</b> Infergen Peg Intron Pegasys Rebetron Actimmune Intron A Proleukin Roferon-A	<b>Platelet Reducing Agents</b> Anagrelide hcl Agrylin		

**Cardiovascular - High Blood Pressure**

Accupril  
Accuretic  
Aceon  
Altace  
Atacand  
Atacand HCT  
Avalide  
Avapro  
Benicar  
Benicar HCT  
Capoten  
Capozide  
Cozaar  
Hyzaar  
Lotensin  
Lotensin HCT  
Mavik  
Micardis  
Micardis HCT  
Monopril  
Monopril HCT  
Prinivil  
Prinzide  
Teveten  
Teveten HCT  
Uniretic  
Univasc  
Vaseretic  
Vasotec  
Zestoretic  
Zestril

**Heartburn/Ulcer**

Aciphex  
Nexium  
Prevacid  
Prilosec  
Protonix  
Zegerid

**Skin Disorders**

Aclovate  
Clobex  
Coraz  
Cutivate  
Dermatop  
Desonate  
Desowen  
Diprolene  
Diprolene AF  
Diprosone  
Elidel  
Elocon  
Halog  
Kenalog  
Lacticare-HC  
Lidex  
Locoid  
Luxiq  
Momexin  
Nucort  
Nuzon  
Olux  
Olux-e  
Olux-Olux-E  
Pandel  
Pediaderm HC  
Protopic  
Psorcon  
Psorcon E  
Scalacort DK  
Temovate  
Topicort  
Topicort LP  
Tridesilon  
Ultravate  
Ultravate PAC  
Valisone  
Vanos  
Verdeso  
Westcort  
Zytopic

**Nerve Pain**

Lyrica

**Overactive Bladder**

Ditropan  
Ditropan XL  
Enablex  
Gelnique  
Sanctura  
Sanctura XR  
Urispas

**Sleep Disorder**

Ambien  
Edluar  
Lunesta  
Rozerem  
Sonata

**Anti-Allergy Inhaled Nasal Steroids**

Beconase AQ  
Flonase  
Nasacort AQ  
Nasarel  
Omnaris  
Rhinocort Aqua  
Veramyst

**Antidepressants**

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

**Bone Health**

Actonel  
Actonel with Calcium  
Fosamax  
Fosamax Plus D  
Skelid

**ADHD Medications**

Adderall  
Daytrana  
Dexedrine  
Dextrostat  
Metadate CD  
Metadate ER  
Methylin  
Ritalin  
Ritalin SR

**Asthma Nebulizer Solutions**

Accuneb  
Brovana  
Perforomist  
Xopenex

**Atypical Antipsychotics**

Abilify  
Abilify Discmelt  
Clozaril  
Fanapt  
Fazaclo  
Geodon  
Invega  
Risperdal  
Risperdal M  
Saphris

## Non-Narcotic Pain

### Relievers

Anaprox  
Ansaid  
Arthrotec  
Cambia  
Cataflam  
Clinoril  
Daypro  
EC-Naprosyn  
Flector Patch  
Indocin SR  
Lodine  
Lodine XL  
Mobic  
Motrin  
Nalfon  
Naprelan  
Naprosyn  
Pennsaid  
Prevacid Naprapac  
Sulindac  
Tolectin DS  
Vimovo  
Voltaren  
Voltaren Gel  
Zipsor

## Oral Narcotic Pain

### Relievers

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

## Authorization

No authorization will be required prior to receiving Emergency Services.

### Non-English Assistance

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

### Utilization Review Procedures

#### *Health Care Services*

The following applies only to the In-Network plan.

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

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

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

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

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

#### *Home Health Services Following a Hospital Admission*

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

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

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

## Health Care Services

A denial of claim or a clinical decision regarding health care services will be made by qualified clinical personnel. Notice of denial or determination will include information regarding the basis for denial or determination and any further appeal rights.

to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours of receipt of the appeal request or two business days of receipt of necessary information. Our failure to render a determination of your internal appeal within this timeframe shall be deemed a reversal of the initial adverse determination. If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal.

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## How To File Your Claim

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

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

### CLAIM REMINDERS

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

### Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 120 days after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service. If claims are not submitted within 120 days, the claim will not be invalidated nor reduced if it is shown that it was submitted as soon as was reasonably possible.

**WARNING:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000.00 and the stated value of the claim for each such violation.

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## Eligibility - Effective Date

### Employee Insurance

This plan is offered to you as an Employee.

#### Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 20 hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

#### Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

### Waiting Period

The first day of the month following 60 days from date of hire.

#### Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

#### Effective Date of Employee Insurance

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

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

**Late Entrant - Employee**

You are a Late Entrant if:

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

**Dependent Insurance**

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

**Effective Date of Dependent Insurance**

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

Your Dependents will be insured only if you are insured.

**Late Entrant – Dependent**

You are a Late Entrant for Dependent Insurance if:

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

**Exception for Newborns**

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

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



## Preferred Provider Medical Benefits

### The Schedule

#### For You and Your Dependents

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

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

#### Coinsurance

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

#### Deductibles

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

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

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

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

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

- Coinsurance.
- Plan Deductible.
- Any benefit deductibles.

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

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

- Non-compliance penalties.
- Provider charges in excess of the Maximum Reimbursable Charge.

#### Accumulation of Plan Deductibles and Out-of-Pocket Maximums

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

#### 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.

## Preferred Provider Medical Benefits

### The Schedule

#### Assistant Surgeon and Co-Surgeon Charges

##### Assistant Surgeon

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

##### Co-Surgeon

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

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Lifetime Maximum for non-Essential and Essential Health Benefits *</b> <b>*(Essential Health benefits are noted throughout the Schedule as EHB)</b>	Unlimited	
<b>The Percentage of Covered Expenses the Plan Pays</b>  <b>Note:</b> "No charge" means an insured person is not required to pay Coinsurance.	90%	70% of the Maximum Reimbursable Charge
<b>Maximum Reimbursable Charge</b>  Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or  A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database Cigna has selected.  <b>Note:</b> The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles and coinsurance.	Not Applicable	90th Percentile

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Calendar Year Deductible</b> Individual Family Maximum Family Maximum Calculation <b>Individual Calculation:</b> Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.	\$100 per person \$300 per family	\$100 per person \$300 per family
<b>Out-of-Pocket Maximum</b> Individual Family Maximum Family Maximum Calculation <b>Individual Calculation:</b> Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.	\$2,000 per person \$3,000 per family	\$4,000 per person \$6,000 per family

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Combined Medical/Pharmacy Out-of-Pocket Maximum</b>  Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery drugs  Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	Yes   Yes	Yes   In-Network coverage only
<b>Physician's Services</b> <b>*EHB</b>  Primary Care Physician's Office Visit  Specialty Care Physician's Office Visits  Consultant and Referral Physician's Services  <b>Note:</b> OB/GYN provider is considered a Specialist.  Surgery Performed in the Physician's Office  Second Opinion Consultations (provided on a voluntary basis)  Allergy Treatment/Injections  Allergy Serum (dispensed by the Physician in the office)	90%   90%      90%  90%  90%  90%	70% after plan deductible   70% after plan deductible      70% after plan deductible  70% after plan deductible  70% after plan deductible
<b>Preventive Care</b> <b>*EHB</b>  Routine Preventive Care - all ages  Immunizations - all ages	No charge  No charge	70% after plan deductible  70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Mammograms</b> <b>*EHB</b> Preventive Care Related Services (i.e. “routine” services) Diagnostic Related Services (i.e. “non-routine” services)	No charge  No charge	No charge  Subject to the plan’s x-ray & lab benefit; based on place of service
<b>PSA, PAP Smear</b> <b>*EHB</b> Preventive Care Related Services (i.e. “routine” services) Diagnostic Related Services (i.e. “non-routine” services)	No charge  Subject to the plan’s x-ray & lab benefit; based on place of service	70% after plan deductible  Subject to the plan’s x-ray & lab benefit; based on place of service
<b>Inpatient Hospital - Facility Services</b> <b>*EHB</b> Semi-Private Room and Board  Private Room  Special Care Units (ICU/CCU)	90%  Limited to the semi-private room negotiated rate  Limited to the semi-private room negotiated rate  Limited to the negotiated rate	70% after plan deductible  Limited to the semi-private room rate  Limited to the semi-private room rate  Limited to the ICU/CCU daily room rate
<b>Outpatient Facility Services</b> <b>*EHB</b> Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	90%	70% after plan deductible
<b>Inpatient Hospital Physician’s Visits/Consultations</b> <b>*EHB</b>	90%	70% after plan deductible
<b>Inpatient Hospital Professional Services</b> <b>*EHB</b> Surgeon Radiologist Pathologist Anesthesiologist	90%	70% after plan deductible
<b>Outpatient Professional Services</b> <b>*EHB</b> Surgeon Radiologist Pathologist Anesthesiologist	90%	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Emergency and Urgent Care Services</b> <b>*EHB</b> Physician's Office Visit Hospital Emergency Room Outpatient Professional Services (radiology, pathology and ER physician) Urgent Care Facility or Outpatient Facility X-ray and/or Lab performed at the Emergency Room Facility (billed by the facility as part of the ER visit) X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit) Independent x-ray and/or Lab Facility in conjunction with an ER visit Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER visit Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the UC visit Ambulance	90% 90% 90% 90% after plan deductible 90% 90% after plan deductible 90% 90% 90% after plan deductible 90% after plan deductible	90% 90% 90% 90% after plan deductible 90% 90% after plan deductible 90% 90% 90% after plan deductible 90% after plan deductible
<b>Inpatient Services at Other Health Care Facilities</b> <b>*EHB</b> Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 120 days combined	90%	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Laboratory and Radiology Services (includes pre-admission testing)</b> <b>*EHB</b> Physician's Office Visit Outpatient Hospital Facility Independent X-ray and/or Lab Facility	90% 90% 90%	70% after plan deductible 70% after plan deductible 70% after plan deductible
<b>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</b> <b>*EHB</b> Physician's Office Visit Inpatient Facility Outpatient Facility	90% 90% 90%	70% after plan deductible 70% after plan deductible 70% after plan deductible
<b>Outpatient Short-Term Rehabilitative Therapy</b> <b>*EHB</b> Calendar Year Maximum: 60 days each Therapy <b>Note:</b> The Short-Term Rehabilitative Therapy maximum does not apply to the treatment of autism. Includes: Physical Therapy Speech Therapy Occupational Therapy Aural Therapy Calendar Year Maximum: 20 days each Therapy Pulmonary Rehab Cognitive Therapy	90%	70% after plan deductible
<b>Outpatient Cardiac Rehabilitation</b> <b>*EHB</b> Calendar Year Maximum: 36 days	90%	70% after plan deductible
<b>Chiropractic Care</b> <b>*EHB</b> Calendar Year Maximum: Unlimited Physician's Office Visit	90%	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Home Health Care</b> <b>*EHB</b> Regardless of the Individual Plan Deductible, the Home Health Care Deductible will not exceed \$50.  Calendar Year Maximum: 150 days (includes outpatient private nursing when approved as Medically Necessary)	100% after the Home Health Care Deductible	75% after the Home Health Care Deductible
<b>Hospice</b> <b>*EHB</b> Inpatient Services Outpatient Services	100% 100%	70% after plan deductible 70% after plan deductible
<b>Bereavement Counseling</b> <b>*EHB</b> Services provided as part of Hospice Care Inpatient Outpatient Services provided by Mental Health Professional	100% 100% Covered under Mental Health benefit	70% after plan deductible 70% after plan deductible Covered under Mental Health benefit
<b>Maternity Care Services</b> <b>*EHB</b> Initial Visit to Confirm Pregnancy  <b>Note:</b> OB/GYN provider is considered a Specialist. All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee) Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist Delivery - Facility (Inpatient Hospital, Birthing Center)	90%  90%  90%  90%	70% after plan deductible  70% after plan deductible  70% after plan deductible  70% after plan deductible



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Abortion</b> <b>*EHB</b> Includes elective and non-elective procedures Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	90% 90% 90% 90%	70% after plan deductible 70% after plan deductible 70% after plan deductible 70% after plan deductible
<b>Women's Family Planning Services</b> <b>*EHB</b> Office Visits, Lab and Radiology Tests and Counseling Surgical Sterilization Procedures for Tubal Ligation (excludes reversals) Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	No charge No charge No charge No charge	70% after plan deductible 70% after plan deductible 70% after plan deductible 70% after plan deductible
<b>Men's Family Planning Services</b> <b>*EHB</b> Office Visits, Lab and Radiology Tests and Counseling Surgical Sterilization Procedures for Vasectomy (excludes reversals) Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	90% 90% 90% 90%	70% after plan deductible 70% after plan deductible 70% after plan deductible 70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Infertility Treatment *EHB (except for In-vitro, GIFT and ZIFT)</b> Coverage will be provided for the following services: <ul style="list-style-type: none"> <li>• Testing and treatment services performed in connection with an underlying medical condition.</li> <li>• Testing performed specifically to determine the cause of infertility.</li> <li>• Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).</li> <li>• Artificial Insemination, In-vitro, GIFT, ZIFT, etc.</li> </ul>		
Physician's Office Visit (Lab and Radiology Tests, Counseling)  Inpatient Facility  Outpatient Facility  Physician's Services  Lifetime Maximum: Unlimited  Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).	90%  90%  90%  90%	70% after plan deductible  70% after plan deductible  70% after plan deductible  70% after plan deductible
<b>Organ Transplants</b> <b>*EHB (Applicable to In-Network Benefits only. Does not include travel).</b> Includes all medically appropriate, non-experimental transplants  Physician's Office Visit  Inpatient Facility  Physician's Services  Lifetime Travel Maximum: \$10,000 per transplant	90%  100% at Lifesource center, otherwise 90%  100% at Lifesource center, otherwise 90%  No charge (only available when using Lifesource facility)	70% after plan deductible  70% after plan deductible  70% after plan deductible  In-Network coverage only
<b>Durable Medical Equipment</b> <b>*EHB</b>  Calendar Year Maximum: Unlimited	90% after plan deductible	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>External Prosthetic Appliances</b> <b>*EHB</b> Calendar Year Maximum: Unlimited	90% after plan deductible	70% after plan deductible
<b>Hearing Aids</b> <b>*EHB</b> Calendar Year Maximum: 2 devices per 36 months	90% after plan deductible	70% after plan deductible
<b>Diabetic Equipment</b> <b>*EHB</b> Calendar Year Maximum: Unlimited	90% after plan deductible	70% after plan deductible
<b>Nutritional Evaluation</b> <b>*EHB (applicable to treatment of diabetes; treatment of eating disorders; and in connection with enteral formulas as a result of an underlying medical condition)</b> Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of diabetes or treatment prescribed in connection with mental health diagnosis. Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	90% 90% 90% 90%	70% after plan deductible 70% after plan deductible 70% after plan deductible 70% after plan deductible
<b>Dental Care</b> <b>*EHB (for oral surgery only)</b> Limited to charges made for a continuous course of dental treatment started within twelve months of an injury to sound, natural teeth and charges made for dental care and treatment due to congenital disease or anomaly. Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	90% 90% 90% 90%	70% after plan deductible 70% after plan deductible 70% after plan deductible 70% after plan deductible

BENEFIT HIGHLIGHTS		IN-NETWORK	OUT-OF-NETWORK
<b>TMJ Surgical and Non-Surgical</b> <b>*EHB</b> Always excludes appliances and orthodontic treatment. Subject to medical necessity.			
Physician's Office Visit	90%		70% after plan deductible
Inpatient Facility	90%		70% after plan deductible
Outpatient Facility	90%		70% after plan deductible
Physician's Services	90%		70% after plan deductible
<b>Routine Foot Disorders</b> <b>*EHB (when provided in connection with treatment of diabetes)</b>		Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.
<b>Treatment Resulting From Life Threatening Emergencies</b> <b>*EHB</b> 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.			
<b>Mental Health</b> <b>*EHB</b>			
<b>Inpatient</b>	90%		70% after plan deductible
<b>Outpatient (Includes Individual, Group and Intensive Outpatient)</b>			
Physician's Office Visit	90%		70% after plan deductible
Outpatient Facility	90%		70% after plan deductible
<b>Substance Abuse</b> <b>*EHB</b>			
<b>Inpatient</b>	90%		70% after plan deductible
<b>Outpatient (Includes Individual and Intensive Outpatient)</b>			
Physician's Office Visit	90%		70% after plan deductible
Outpatient Facility	90%		70% after plan deductible

## Preferred Provider Medical Benefits

### Utilization Review

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

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

### Preauthorization Reviews

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

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

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

within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

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

### Concurrent Reviews

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

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

### Retrospective Reviews

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

the earlier of our receipt of the information or the end of the 45 day period.

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

#### **Retrospective Review of Preauthorized Services**

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

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

#### **Reconsideration**

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

#### **Utilization Review Internal Appeals**

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

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

Review Appeal of denial of an Out-of-Network health service, you, or your designee, must submit:

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

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

#### **First Level Appeal**

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

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

**Expedited Appeals.** Appeals of reviews of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. Expedited Appeals are not available for retrospective reviews. For Expedited Appeals, your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal

within one business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited Appeals will be determined within the lesser of 72 hours from receipt of the Appeal or two business days of receipt of the information necessary to conduct the Appeal.

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

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

### **Second Level Appeal**

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

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

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

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

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

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

## **Certification Requirements - Out-of-Network For You and Your Dependents**

### **Pre-Admission Certification/Continued Stay Review for Hospital Confinement**

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

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

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

You or your Dependent; should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 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 the lesser of 50% or \$500 of Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 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 be reduced by the lesser of 50% or \$500:

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

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

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

### Outpatient Certification Requirements - Out-of-Network

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

Covered Expenses incurred will be reduced by the lesser of 50% or \$500 for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

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

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

### Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Hysterectomy.

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### Prior Authorization/Pre-Authorized

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

Services that require Prior Authorization:

- inpatient Hospital services, except for 48/96 hour maternity stays;

- inpatient services at any participating Other Health Care Facility;
- outpatient facility services;
- intensive outpatient programs;
- advanced radiological imaging;
- non-emergency ambulance; or
- transplant services.

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### Covered Expenses

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

### Covered Expenses

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



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

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

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

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

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

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

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

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

Coverage for air ambulance related to an Emergency Medical Condition or air ambulance related to non-emergency transportation is provided when a covered person’s medical condition is such that transportation by

land ambulance is not appropriate; **and** that medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; **and** one of the following is met:

- the point of pick-up is inaccessible by land vehicle; or
- great distances or other obstacles (for example, heavy traffic) prevent timely transfer to the nearest Hospital with appropriate facilities.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services for the treatment of an Emergency Medical Condition and for Urgent Care. Coverage for Emergency Services for treatment of an Emergency Medical Condition is provided regardless of whether the provider is a Participating Provider. Coverage for Emergency Services for treatment of an Emergency Medical Condition is provided worldwide. However, only Emergency Services and supplies that are medically Necessary and are performed to treat to stabilize and Emergency Medical Condition are covered.
- **Hospital Emergency Department Visits.** In the event that a covered person requires treatment for an Emergency Medical Condition, that person should seek immediate care at the nearest Hospital emergency department or call 911. Emergency department care does not require preauthorization. **However, only Emergency Services for the treatment of an Emergency Medical Condition, as defined, are covered in an emergency department.** Follow-up care or routine care provided in a Hospital emergency department is not covered.
- **Emergency Hospital Admissions.** In the event a covered person is admitted to the Hospital, the covered person or someone acting on his or her behalf must notify Cigna at the telephone number listed on the ID card within 48 hours of admission, or as soon as is reasonably possible.
- **Payments Relating to Emergency Services Rendered.** The amount paid to non-Participating Providers for Emergency Services will be the greater of: the amount that Cigna negotiated with Participating Providers for the Emergency Services received (and if more than one amount

is negotiated, the median of the amounts); 100% of the allowed amount for services provided by a non-Participating Provider (i.e., the amount Cigna would pay in the absence of any cost-sharing that would otherwise apply for services of non-Participating Providers; or the amount that would be paid under Medicare. These amounts exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.

- **Urgent Care.** Urgent Care may be obtained from a Participating Provider or a Participating Urgent Care center, as well as from a non-Participating Urgent Care center or Physician. **If Urgent Care results in an Emergency admission, the standards for Emergency Hospital admissions described above apply.**
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for X-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.
- charges made for interruption of pregnancy, as follows: therapeutic abortions; non-therapeutic abortions in cases of rape, incest or fetal malformation; elective abortions.
- **Preventive Care.** The following services are covered for the purpose of promoting good health and early detection of disease. Preventive services are not subject to cost-sharing (Copayments, Deductibles, and Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have a "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, cost-sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply. Contact Cigna at the number shown on your ID card or visit [www.mycigna.com](http://www.mycigna.com) for a copy of the comprehensive guidelines supported by HRSA, items or services with an

"A" or "B" rating from the USPSTF, and immunizations recommended by ACIP.

- **Well-Baby and Well-Child Care.** Coverage is provided for well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. Preventive Care and screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF are also covered. If the schedule of well-child visits referenced above permits one well-child visit per calendar year, Cigna will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also covered. This benefit is provided to covered persons from birth through attainment of age 19 and is not subject to Copayments, Deductible or Coinsurance when provided by a Participating Provider.
- **Adult Annual Physical Examinations.** Annual physical examinations and preventive care and screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF are covered. Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening and diabetes screening. A complete list of the covered preventive services is available on our website at [www.mycigna.com](http://www.mycigna.com), or will be mailed upon request.  
  
Covered persons are eligible for a physical exam once every contract year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.  
  
This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.
- **Adult Immunizations.** Adult immunizations as recommended by ACIP are covered. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.
- **Well-Woman Examinations.** Well-woman examinations which consist of routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear are covered. Preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from

USPSTF are also covered. A complete list of the covered preventive services is available on our website at [www.mycigna.com](http://www.mycigna.com), or will be mailed upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

- **Mammograms.** Mammograms for the screening of breast cancer are covered as follows:

- one baseline screening mammogram for women age 35 through 39;
- one baseline screening mammogram annually for women age 40 and over.

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

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

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

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

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

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

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

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

- **Bone Mineral Density Measurements or Testing.** Bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic

equivalents as approved substitutes are covered. Coverage of Prescription Drugs is subject to the Prescription Drug section of the Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. A covered person will also qualify for coverage of bone mineral density measurements and testing if he or she meets any of the following:

- previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- with symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
- on a prescribed drug regimen posing a significant risk of osteoporosis; or
- with lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- with such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

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

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

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

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

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

for which surgery is to be performed; reservations for a Hospital bed and operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the Hospital for the tests.

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

- Drawing-up devices for the visually impaired
- Equipment for use of the Pump
- Glucose Acetone Reagent Strips
- Glucose Reagent Strips
- Glucose Reagent Tape
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin Cartridge Delivery
- Insulin infusion devices
- Insulin Pump
- Lancets
- Oral agents such as glucose tablets and gels
- Glucagon for injection to increase blood glucose concentration
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.
- self-management education. Diabetes self-management education is education designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition including information on proper diets. Cigna covers education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in your symptoms or condition which necessitates a change in your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:
  - by a Physician, other health care provider authorized to prescribe under Title 8 of the Education Law, or their staff during an office visit;
  - upon the referral of your Physician or other health care provider authorized to prescribe under Title 8 of the Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
  - education will also be provided in your home when Medically Necessary.
- Limitations. The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for you. Cigna covers only basic models of blood glucose monitors unless you have special needs relating to poor vision or blindness.
- charges for enteral formulas, whether administered orally or via feeding tube, for home use for the treatment of: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies. The Physician must issue a written order stating that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for individuals who are or will become malnourished or suffer from disorders which, if left untreated, cause chronic physical disability, mental retardation or death. Covered expenses will also include modified solid food products that are low protein or which contain modified protein, which are Medically Necessary. Such coverage for any calendar year or continuous 12-month period will be limited to \$2,500, applicable to Out-of-Network benefits only.
- charges for the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Cigna to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).
- Screening and Diagnosis. Cigna covers assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.
- Assistive Communication Devices. Cigna covers a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, Cigna covers the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if you are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide you with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices; Cigna will only cover devices that generally are not useful to a person in the absence of a communication impairment. We will not cover items, such as, but not limited to, laptops, desktop, or tablet computers. Cigna

covers software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. Cigna will determine whether the device should be purchased or rented.

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

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

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

- **Psychiatric and Psychological Care.** Cigna covers direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.
- **Therapeutic Care.** Cigna covers therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to

services of such therapists or social workers under this Certificate.

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

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

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

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

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

the External Appeal Agent renders a decision in Cigna's favor.

Cigna will reimburse non-Participating Providers for this end of life care as follows:

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

Limitations/Terms of Coverage:

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

### **Clinical Trials**

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

- (a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and
- (b) either
  - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
  - the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

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

The clinical trial must meet the following requirements:

The study or investigation must:

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

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

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

Routine patient care costs do not include:

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

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

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

### **Genetic Testing**

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

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

genetically-linked inheritable disease when the results will impact clinical outcome; or

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

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

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

#### **Nutritional Evaluation**

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

#### **Internal Prosthetic/Medical Appliances**

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

HC-COV347

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10-15

#### **Orthognathic Surgery**

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

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

HC-COV3

04-10

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#### **Cardiac Rehabilitation**

- 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.

HC-COV4

04-10

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#### **Home Health Services**

Home health services for care provided in a covered person's home by a Home Health Agency certified or licensed by the appropriate state agency are covered.

The care must be provided pursuant to your Physician's written treatment plan and must be in lieu of hospitalization or confinement in a Skilled Nursing Facility. Home care includes (i) part-time or intermittent nursing care by or under the supervision of a Registered Professional Nurse (RN), (ii) part-time or intermittent services of a home health aide, (iii) physical, occupational or speech therapy provided by the Home Health agency, and (iv) medical supplies, drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health agency to the extent such items would have been covered during a hospitalization or confinement in a Skilled Nursing Facility.



Home health services are limited as shown in the Schedule. Each visit by a member of the Home Health agency is considered one visit. Each visit of up to four hours by a home health aide is one visit. Please note: Any rehabilitation services received under this benefit will not reduce the amount of services available under Short-term Rehabilitative Therapy.

HC-COV351

01-15  
V1

### Hospice Care Services

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

HC-COV6

04-10  
V1

### Mental Health Care and Substance Abuse Services

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

#### Mental Health Care Services

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

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

#### Limitations/Terms of Coverage:

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

#### Substance Abuse Services

**Inpatient Services:** Cigna covers inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes

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

**Outpatient Services:** Cigna covers outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by Physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation; and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.

Cigna also covers outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for substance use, and/or dependence. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

HC-COV352

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V1

### Durable Medical Equipment

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

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

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

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

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04-10  
V2

### External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. 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;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;

- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

### **Braces**

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

The following braces are specifically excluded: Copes scoliosis braces.

### **Splints**

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

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

- replacement 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;
  - no more than once every 12 months for persons 18 years of age and under; and
  - replacement due to a surgical alteration or revision of the site.

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

The following are specifically excluded external prosthetic appliances and devices:

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

HC-COV58

04-10  
V1

### **Infertility Services**

- charges made for services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is

the result of malformation, disease or dysfunction. Such coverage is available as follows:

- **Basic Infertility Services.** Basic Infertility Services will be provided to a covered person who is an appropriate candidate for infertility treatment. In order to determine eligibility, Cigna will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, the covered person must be between the ages of 21 and 44 (inclusive) in order to be a candidate for these services. Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, endometrial biopsy, pelvic ultrasound, hysterosalpingogram, sono-hystrogram, testis biopsy, blood tests and medically appropriate treatment of ovulatory dysfunction. Additional tests may be covered if the tests are determined to be Medically Necessary.
- **Comprehensive Infertility Services.** If the basic Services do not result in increased fertility, Cigna covers Comprehensive Infertility Services. These services include: ovulation induction and monitoring; pelvic ultrasound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.
- **Additional Infertility Services.** Cigna will also cover: infertility drugs which are administered or provided by a Physician, sperm washing or preparation; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT).

**Exclusions and Limitations:**

- cost for an ovum donor or donor sperm.
- sperm storage costs.
- cryopreservation and storage of embryos.
- ovulation predictor kits.
- reversal of tubal ligations. Reversal of vasectomies.
- all costs for and relating to surrogate motherhood (maternity services are provided for covered persons acting as surrogate mothers).
- sex change procedures.
- cloning.
- medical and surgical procedures that are experimental or investigational unless Cigna's denial of such procedure is overturned by an External Appeal Agent.

- all services must be provided by providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

HC-COV349

01-15  
V2

### **Short-Term Rehabilitative Therapy**

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

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

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

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

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

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

### **Chiropractic Care Services**

Cigna covers charges for chiropractic care when performed by a Doctor of Chiropractic ("Chiropractor") in connection with correction or detection by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference and effects thereof, where such interference is the result of or

related to distortion, misalignment, or subluxation of or in the vertebral column. This includes assessment, manipulation and any modalities. Any Medically Necessary laboratory tests will be covered in accordance with the terms and conditions of this Certificate.

HC-COV350

01-15  
V1

### **Breast Reconstruction and Breast Prostheses**

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

### **Reconstructive Surgery**

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

HC-COV64

04-10  
V1

### **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<sup>®</sup> facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network<sup>®</sup> facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LIFESOURCE Transplant Network<sup>®</sup> facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are covered at the Out-of-Network level.

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

### **Transplant Travel Services**

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

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

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

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

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## Conversion Right To New Policy After Termination

You have the right to convert to a new Policy if coverage under this Certificate terminates under the circumstances described below.

- **Termination of the Group Policy.** If the Group Policy between Cigna and the Group Policyholder is terminated as set forth in the Policy, and the Group Policyholder has not replaced the coverage for the Group with similar and continuous health care coverage, whether insured or self-insured, you are entitled to purchase a new Policy as direct payment members.
- **If You Are No Longer Covered in a Group.** If your coverage terminates under this Certificate because you are no longer a member of a Group, you are entitled to purchase a new Policy as a direct payment member.
- **On the Death of the Employee.** If coverage terminates under this Certificate because of the death of the Employee, the Employee's Dependents are entitled to purchase a new Policy as direct payment members.
- **Termination of Your Marriage.** If a Spouse's coverage terminates under this Certificate because the Spouse becomes divorced from the Employee or the marriage is annulled, that former Spouse is entitled to purchase a new Policy as a direct payment member.
- **Termination of Coverage of a Child.** If a Dependent child's coverage terminates under this Certificate because the child no longer qualifies as a Dependent child, the child is entitled to purchase a new Policy as a direct payment member.
- **Termination of Your Temporary Continuation of Coverage.** If coverage terminates under this Certificate because you are no longer eligible for continuation of coverage, you are entitled to purchase a new Policy as a direct payment member.
- **Termination of Your Young Adult Coverage.** If a Dependent child's young adult coverage terminates under this Certificate, the child is entitled to purchase a new Policy as a direct payment member.

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

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

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

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## 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.

### Copayments

Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies.

#### Note:

If the cost of a covered Prescription Drug or Related Supply is less than the copayment for that Prescription Drug or Related Supply, you or your Dependent are responsible for the lesser amount.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
<b>Lifetime Maximum</b>	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
<b>Out-of-Pocket Maximum</b>		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
<b>Retail Prescription Drugs</b>	<b>The amount you pay for each 31-day supply</b>	<b>The amount you pay for each 31-day supply</b>
Certain medications covered under this plan and required as part of preventive care services (detailed information is available at <a href="http://www.healthcare.gov">www.healthcare.gov</a> ) are payable at 100% with no copayment or deductible, when purchased from a Participating Pharmacy. A written prescription is required.		
<b>Tier 1</b>		
Generic* drugs on the Prescription Drug List	No charge after \$10 copay	No charge after \$10 copay
<b>Tier 2</b>		
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after \$30 copay	No charge after \$30 copay
<b>Tier 3</b>		
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after \$50 copay	No charge after \$50 copay

BENEFIT HIGHLIGHTS		PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
* Designated as per generally-accepted industry sources and adopted by the Insurance Company			
Home Delivery Prescription Drugs	The amount you pay for each 90-day supply	The amount you pay for each 90-day supply	
Certain medications covered under this plan and required as part of preventive care services (detailed information is available at <a href="http://www.healthcare.gov">www.healthcare.gov</a> ) are payable at 100% with no copayment or deductible, when purchased from a Participating Pharmacy. A written prescription is required.			
<b>Tier 1</b>  Generic* drugs on the Prescription Drug List	No charge after \$10 copay	In-Network coverage only	
<b>Tier 2</b>  Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after \$30 copay	In-Network coverage only	
<b>Tier 3</b>  Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after \$50 copay	In-Network coverage only	
* Designated as per generally-accepted industry sources and adopted by the Insurance Company			



## Prescription Drug Benefits

### For You and Your Dependents

#### Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Schedule.

Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

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

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

#### Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Participating Pharmacy unless limited by the drug manufacturer's packaging; or
- up to a consecutive 90-day supply at a home delivery Participating Pharmacy, unless limited by the drug manufacturer's packaging; or

- to a dosage and/or dispensing limit as determined by the P&T Committee.

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Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.

In the event that you or your Physician insists on a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the required Copayment identified in the Schedule. Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to Cigna to request a prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

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

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

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

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred

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

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## Your Payments

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

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

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

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## Exclusions

No payment will be made for the following expenses:

- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee, unless Medically Necessary and approved by Cigna;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription and nonprescription supplies (such as ostomy supplies), devices (other than FDA approved medicines or devices prescribed to detect or treat bone mineral density conditions), and appliances other than Related Supplies;
- implantable contraceptive products;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasm, and decreased libido, unless Medically Necessary;
- prescription vitamins (other than prenatal vitamins), dietary supplements, unless state or federal law requires coverage of such drugs;
- diet pills or appetite suppressants (anorectics), unless determined to be Medically Necessary and approved by Cigna;
- prescription smoking cessation products, unless determined to be Medically Necessary and approved by Cigna;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products, unless determined to be Medically Necessary and approved by Cigna;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance, unless determined to be Medically Necessary and approved by Cigna;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue;

- any drugs that are experimental or investigational as described under the Medical “Exclusions” section of your certificate.

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

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## 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 unless you are unable to purchase Prescription Drugs at a Participating Pharmacy for Emergency Services.

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

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

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

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## Exclusions and Limitations of Coverage

### Exclusions and Expenses Not Covered

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

- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in functional defect.

- foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
- treatment provided in a government hospital.
- benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability or occupational disease law.
- services rendered and separately billed by employees of hospitals, laboratories or other institutions.
- services performed by a member of the covered person's immediate family.
- dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.
- eyeglasses and examination for the prescription or fitting thereof.
- rest cures and custodial care.
- expenses incurred outside the United States, its possessions or the countries of Canada and Mexico, other than expenses for Medically Necessary urgent or emergent Care while temporarily traveling abroad.

### Exclusions and Expenses Not Covered Unless Medically Necessary

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

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- dental implants for any condition.
- for or in connection with experimental, investigational or unproven services. However, Cigna will cover an experimental or investigational treatment approved by an external appeal agent. If the external appeal agent approved coverage of an experimental or investigational treatment

that is part of a clinical trial, Cigna will only cover the costs of services required to provide treatment to you according to the design of the trial. Cigna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or the costs which would not be covered under this plan for nonexperimental or noninvestigational treatments provided in such clinical trial.

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

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section(s) of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” section(s) of this plan.
- charges made for drugs and implanted/injected devices for contraception.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

### **Limitations of Coverage**

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

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

- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, and elastic stockings.
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- expenses denied by a Primary Plan because treatment was received from a nonparticipating provider.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary, except as specified in any certification requirement shown in this plan.

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## **Coordination of Benefits**

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

### **Definitions**

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

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

- Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially

similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

- Medical benefits coverage, in group and individual automobile “no-fault” and traditional liability “fault” type contracts.
- Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

“Primary plan” is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: the plan has no order of benefits rules or its rules differ from those required by regulation; or all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

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

#### Rules to Determine Order of Payment

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

- If the other plan does not have a provision similar to this one, then the other plan will be primary.
- If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.
- If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
- If a child is covered by both parents’ plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child’s health care expenses:
  - The plan of the parent who has custody will be primary.
  - If the parent with custody has remarried, and the child is also covered as a child under the step-parent’s plan, the plan of the parent with custody will pay first, the step-

parent’s plan will pay second, and the plan of the parent without custody will pay third.

- If a court decree between the parents says which parent is responsible for the child’s health care expenses, then that parent’s plan will be primary if that plan has actual knowledge of the decree.
- If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
- If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

#### Effects of Coordination

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

#### Right to Receive and Release Necessary Information

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

#### Our Right to Recover Overpayment

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

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

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

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

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

#### **Medicare Eligibles**

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

- (a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;
- (d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;
- (e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;
- (f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

Cigna will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.

- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

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

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

#### **Domestic Partners**

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

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## **Payment of Benefits**

### **To Whom Payable**

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

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

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

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The

executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

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

#### **Time of Payment**

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

#### **Recovery of Overpayment**

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

#### **Calculation of Covered Expenses**

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

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

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## **Termination of Insurance**

### **Employees**

Your insurance will cease on the earliest date below:

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

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

#### **Temporary Layoff or Leave of Absence**

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

### **Injury or Sickness**

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

### **Dependents**

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

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

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

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

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

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

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

#### **Conversion Available Following Continuation**

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

#### **Interaction with Other Continuation Benefits**

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

#### **Special Continuation of Medical Insurance for Military Reservists and Their Dependents**

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

- the last day for which the required premium has been paid;
- the date you or your Dependent becomes eligible for insurance under another group policy, other than the

Civilian Health and Medical Program of the Uniformed Services;

- the date you become eligible for Medicare.

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

#### **Provisions Regarding Notification and Election of Special Continuation**

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

#### **Conversion Available Following Continuation**

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

#### **Reinstatement of Medical Insurance for Military Reservists and Their Dependents**

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

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

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

#### **Provisions Applicable to Reinstatement**

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

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

A Dependent child of a Covered Person who meets the limiting age for coverage of a Dependent, is eligible to



continue coverage for himself through age 29, provided he meets all of the following criteria for this continuation coverage:

- is a Covered Person's Dependent child as defined under this plan (other than any requirement requiring financial dependence on a Covered Person); and
- has reached the limiting age as specified under this plan, but has not yet reached his 30<sup>th</sup> birthday; and
- is unmarried; and
- lives, works, or resides in New York or within Cigna's service area; and
- is not insured or eligible for coverage under any employee health benefits plan, whether insured or self-insured; and
- is not covered under Medicare.

To obtain continued coverage under this provision, a written election for continuation coverage, together with the first premium payment required to establish premium payment on a monthly basis, in advance, must be made:

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

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

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

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

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

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

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

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## Rescissions

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

HC-TRM80

01-11

## Medical Benefits Extension

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

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

### Totally Disabled

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

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

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

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

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## Federal Requirements

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

HC-FED1

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### Notice of Provider Directory/Networks

#### Notice Regarding Provider Directories and Provider Networks

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

#### Notice Regarding Pharmacy Directories and Pharmacy Networks

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

HC-FED78

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## Qualified Medical Child Support Order (QMCSO)

### Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as

required by the order and you will not be considered a Late Entrant for Dependent Insurance.

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

### Qualified Medical Child Support Order Defined

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

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

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

### Payment of Benefits

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

HC-FED4

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

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

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of Employer contributions (excluding continuation coverage).** If a current or former Employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the Employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an Employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

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

be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

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

HC-FED96

04-17

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

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

### **A. Coverage elections**

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

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

### **B. Change of status**

A change in status is defined as:

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

### **C. Court order**

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

### **D. Medicare or Medicaid eligibility/entitlement**

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

### **E. Change in cost of coverage**

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

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

### **F. Changes in coverage of spouse or Dependent under another employer's plan**

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

### **G. Reduction in work hours**

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

### **H. Enrollment in a Qualified Health Plan (QHP)**

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

HC-FED95

04-17

## **Eligibility for Coverage for Adopted Children**

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

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

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

HC-FED67

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## **Coverage for Maternity Hospital Stay**

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

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

HC-FED11

10-10

## **Women's Health and Cancer Rights Act (WHCRA)**

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

HC-FED12

10-10

## **Group Plan Coverage Instead of Medicaid**

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

HC-FED13

10-10

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

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

### **Continuation of Health Insurance During Leave**

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

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

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

### **Reinstatement of Canceled Insurance Following Leave**

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

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

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

HC-FED93

10-17

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

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

### **Continuation of Coverage**

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

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

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

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

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

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

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

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

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

aggravated during the military leave, full Plan limitations will apply.

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

HC-FED18 M

10-10

## **Claim Determination Procedures under ERISA**

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

### **Procedures Regarding Medical Necessity Determinations**

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

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

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

### **Preservice Determinations**

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

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

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

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

### **Concurrent Determinations**

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

### **Postservice Determinations**

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

If more time is needed because necessary information is missing from the request, the notice will also specify what

information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

### **Notice of Adverse Determination**

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

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03-13

## **COBRA Continuation Rights Under Federal Law**

### **For You and Your Dependents**

#### **What is COBRA Continuation Coverage?**

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage

area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

#### **When is COBRA Continuation Available?**

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

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

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

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

#### **Who is Entitled to COBRA Continuation?**

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

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

#### **Secondary Qualifying Events**

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second

qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

#### **Disability Extension**

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

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

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

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

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

#### **Medicare Extension for Your Dependents**

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

#### **Termination of COBRA Continuation**

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

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;



- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

#### **Moving Out of Employer's Service Area or Elimination of a Service Area**

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

#### **Employer's Notification Requirements**

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

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the

occurrence of a qualifying event, 44 days after the qualifying event occurs; or

- in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

#### **How to Elect COBRA Continuation Coverage**

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

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

#### **How Much Does COBRA Continuation Coverage Cost?**

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

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

## **When and How to Pay COBRA Premiums**

### *First payment for COBRA continuation*

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

### *Subsequent payments*

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

### *Grace periods for subsequent payments*

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

## **You Must Give Notice of Certain Qualifying Events**

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

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

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

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

## **Newly Acquired Dependents**

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

## **COBRA Continuation for Retirees Following Employer’s Bankruptcy**

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

## **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.

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07-14

### ERISA Required Information

The name of the Plan is:

JPMorgan Chase Medical Plan

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

JPMorgan Chase Bank, NA  
545 Washington Boulevard, 12th Floor  
Jersey City, NJ 07310  
877-576-2427

Employer Identification  
Number (EIN):

134994650

Plan Number:

502

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

JPMorgan Chase U.S. Benefits Executive c/o JPMorgan  
Chase & Co Benefits Administration  
545 Washington Boulevard, 12th Floor  
Jersey City, NJ 07310  
877-576-2427

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

JPMorgan Chase & Co  
4 Chase Metrotech Center FL 18, NY1-C312  
Brooklyn, NY 11245  
212-552-4745

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

The Cigna Claim Office responsible for this Plan

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

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

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

### Plan Type

The plan is a healthcare benefit plan.

### Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a

sponsor. A copy is available for examination from the Plan Administrator upon written request.

### Discretionary Authority

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

### Plan Modification, Amendment and Termination

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

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

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

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

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

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

### **Statement of Rights**

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

#### **Receive Information About Your Plan and Benefits**

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

#### **Continue Group Health Plan Coverage**

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

#### **Prudent Actions by Plan Fiduciaries**

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

#### **Enforce Your Rights**

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan

and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

#### **Assistance with Your Questions**

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

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05-15

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

#### **Certificate Rider**

Policyholder: JPMorgan Chase & Co.

Rider Eligibility: Each Employee

Policy No. or Nos. 3174696-HAWAI

Effective Date: January 1, 2020

You will become insured on the date you become eligible if you are in Active Service on that date or if you are not in Active Service on that date due to your health status. If you are not insured for the benefits described in your certificate on that date, the effective date of this certificate rider will be the date you become insured.

This certificate rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified above.

  
*Anna Krishtul, Corporate Secretary*

HC-RDR31

04-10  
V1

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

**Note:**

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

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

The "charges made for Family Planning, including medical history..." sub-item is changed to read:

- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).

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

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

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

- charges made for drugs, and implanted/injected devices, for contraception.

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

- implantable contraceptive products;

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

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## Notice of an Appeal or a Grievance

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

HC-SPP4

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V1

## Grievance

**Grievances.** Cigna's Grievance procedure applies to any issue not relating to Medical Necessity or experimental or investigational determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding Cigna's administrative policies or access to providers.

**Filing a Grievance.** You can contact Cigna by phone at the toll-free number on your Benefit Identification card, explanation of benefits or claim form or in writing to file a Grievance to:

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

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

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

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

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

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

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

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

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

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

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

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

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

New York State Department of Financial Services  
Consumer Assistance Unit  
One Commerce Plaza  
Albany, NY 12257  
[www.dfs.ny.gov](http://www.dfs.ny.gov)

If you need assistance filing a Grievance or Appeal, you may also contact the state independent Consumer Assistance program at:

Community Health Advocates  
105 East 22<sup>nd</sup> Street  
New York, NY 10010  
or call toll-free: 1-888-614-5400  
or email [cha@cssny.org](mailto:cha@cssny.org)

## External Appeal

### I. Your Right to an External Appeal

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

Agent, an independent third party certified by the State to conduct these Appeals.

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

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

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

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

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

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

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

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or

- A clinical trial for which you are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending Physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

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

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

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

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

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

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

## **V. The External Appeal Process**

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

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

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

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

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

If the External Appeal Agent overturns our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment we will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We will not be responsible

for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Certificate for non-experimental or non-investigational treatments provided in the clinical trial.

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

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

## **VI. Your Responsibilities**

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

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

### **Notice of Benefit Determination on Grievance or Appeal**

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



of adverse determination will include a discussion of the decision.

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

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

### Relevant Information

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

### Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna

until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

HC-APL226

01-15  
V1

## Definitions

### Active Service

You will be considered in Active Service:

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

HC-DFS1

04-10  
V1

### Bed and Board

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

HC-DFS2

04-10  
V2

### Charges

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

HC-DFS153

04-10  
V1

### Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to

specific joints to restore motion, reduce pain and improve function.

HC-DFSS5

04-10  
V1

## Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

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

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

The term child means a child born to you or a child legally adopted by you from the start of any waiting period prior to the finalization of the child's adoption. It also includes a newborn infant who is adopted by you from the moment you take physical custody of the child upon the child's release from the hospital prior to the finalization of the child's adoption. It also includes a stepchild, a foster child, or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

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

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

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

HC-DFS698

01-15  
V1

## Domestic Partner

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

- shares your permanent residence, as demonstrated by a driver's license, tax return or other sufficient proof;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements:
  - a joint bank account;
  - a joint credit card or charge card;
  - joint obligation on a loan;
  - status as an authorized signatory on the partner's bank account, credit card or charge card;
  - joint ownership of holdings or investments;
  - joint ownership of residence;
  - joint ownership of real estate other than residence;
  - listing of both partners as tenants on the lease of the shared residence;
  - shared rental payments of residence (this need not be shared 50/50);
  - listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
  - a common household and shared household expenses, e.g. grocery bills, utility bills, telephone bills, etc. (this need not be shared 50/50);
  - shared household budget for purposes of receiving government benefits;
  - status of one as representative payee for the other's government benefits;
  - joint ownership of major items of personal property, e.g. appliances, furniture;
  - joint ownership of a motor vehicle;
  - joint responsibility for child care, e.g. school documents, guardianship;
  - shared child-care expenses, e.g. babysitting, day care, school bills (this need not be shared 50/50);
  - execution of wills naming each other as executor and/or beneficiary;
  - designation as beneficiary under the other's life insurance policy;
  - designation as beneficiary under the other's retirement benefits account;
  - mutual grant of durable power of attorney;
  - mutual grant of authority to make health care decisions, e.g. health care power of attorney;

- affidavit by creditor or other individual able to testify to partners' financial interdependence; or
- such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

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

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

HC-DFS420

04-10  
V1

### Emergency Medical Condition

The term Emergency medical condition means a medical condition or behavioral condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

- serious disfigurement of such person.

HC-DFS416

11-10  
V1

### Emergency Services

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

HC-DFS393

11-10

### 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 20 hours a week for the Employer.

HC-DFS7

04-10  
V3

### Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8

04-10  
V1

### Essential Health Benefits

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

HC-DFS411

01-11

### Expense Incurred

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

HC-DFS10

04-10  
V1

### Free-Standing Surgical Facility

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

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

HC-DFS11

04-10  
V1

### Hospice Care Program

The term Hospice Care Program means:

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

HC-DFS51

04-10  
V1

### Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar

institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

HC-DFS52

04-10  
V1

### Hospice Facility

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

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

HC-DFS53

04-10  
V1

### Hospital

The term Hospital means:

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

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

HC-DFS48

04-10  
V1

## Hospital Confinement or Confined in a Hospital

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

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

HC-DFS49

04-10  
V1

## Injury

The term Injury means an accidental bodily injury.

HC-DFS12

04-10  
V1

## Maintenance Treatment

The term Maintenance Treatment means:

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

HC-DFS56

04-10  
V1

## Maximum Reimbursable Charge - Medical

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

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

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

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

HC-DFS13

04-10  
V21

## Medicaid

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

HC-DFS16

04-10  
V1

## 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.

HC-DFS19

04-10  
V1

## Medicare

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

HC-DFS17

04-10  
V1

## Necessary Services and Supplies

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

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

HC-DFS21

04-10  
V1

### **Nurse**

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

HC-DFS22

04-10  
V1

### **Other Health Care Facility/Other Health Professional**

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

HC-DFS23

04-10  
V1

### **Participating Pharmacy**

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

HC-DFS60

04-10  
V1

### **Participating Provider**

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

HC-DFS45

04-10  
V1

### **Patient Protection and Affordable Care Act of 2010 ("PPACA")**

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

HC-DFS412

01-11

### **Pharmacy**

The term Pharmacy means a retail Pharmacy, or a home delivery Pharmacy.

HC-DFS61

04-10  
V1

### **Pharmacy & Therapeutics (P & T) Committee**

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

HC-DFS62

04-10  
V1

### **Physician**

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

- operating within the scope of his license; and

- performing a service for which benefits are provided under this plan when performed by a Physician.

HC-DFS25

04-10  
V1

### Prescription Drug

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

HC-DFS63

04-10  
V1

### 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.

HC-DFS64

04-10  
V1

### 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.

HC-DFS65

04-10  
V1

### Preventive Treatment

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

HC-DFS57

04-10  
V1

### Primary Care Physician

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

HC-DFS40

04-10  
V1

### Psychologist

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

HC-DFS26

04-10  
V1

### 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.

HC-DFS68

04-10  
V1

### Review Organization

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

HC-DFS30

04-10  
V1

### Sickness – For Medical Insurance

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

HC-DFS50

04-10  
V1

### Skilled Nursing Facility

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

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

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

HC-DFS31

04-10  
V1

### Specialist

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

HC-DFS33

04-10  
V1

### Stabilize

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

HC-DFS413

01-11

### Terminal Illness

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

HC-DFS54

04-10  
V1

### Urgent Care

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

HC-DFS34

04-10  
V1



## SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.  
For - JPMorgan Chase  
PPO Plan  
Hawaii Plan  
Effective - 01/01/2020



**Selection of a Primary Care Provider** - your plan may require or allow 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 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](http://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.

**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](http://www.mycigna.com) or contact customer service at the phone number listed on the back of your ID card.

Plan Highlights	In-Network	Out-of-Network
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Plan Coinsurance</b>	Your plan pays 90%	Your plan pays 70%
<b>Maximum Reimbursable Charge</b>	Not Applicable	90th Percentile
<b>Calendar Year Deductible</b>	Individual: \$100 Family: \$300	Individual: \$100 Family: \$300
<ul style="list-style-type: none"> <li>The amount you pay for all covered expenses counts towards both your in-network and out-of-network deductibles.</li> <li>Copays always apply before plan deductible and coinsurance.</li> <li>Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.</li> </ul> <p><b>Note:</b> Services where plan deductible applies are noted with a caret (^).</p>		
<b>Calendar Year Out-of-Pocket Maximum</b>	Individual: \$2,500 Family: \$7,500	Individual: \$2,500 Family: \$7,500
<ul style="list-style-type: none"> <li>The amount you pay for all covered expenses counts towards both your in-network and out-of-network out-of-pocket maximums.</li> <li>Plan deductible contributes towards your out-of-pocket maximum.</li> <li>All copays and benefit deductibles contribute towards your out-of-pocket maximum.</li> <li>Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.</li> <li>After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.</li> <li>Penalties for failure to obtain pre-authorization for services contribute towards your out-of-pocket maximum.</li> <li>This plan includes a combined Medical/Pharmacy out-of-pocket maximum.</li> </ul>		

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Benefit	In-Network	Out-of-Network
<b>Physician Services - Office Visits</b>		
<b>Physician Office Visit – Primary Care Physician (PCP)</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Physician Office Visit – Specialist</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>NOTE:</b> Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
<b>Surgery Performed in Physician's Office - PCP</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Surgery Performed in Physician's Office – Specialist</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Allergy Treatment/Injections Performed in Physician's Office PCP</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Allergy Treatment/Injections Performed in Specialist Office</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Allergy Serum - PCP</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Allergy Serum - Specialist</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<ul style="list-style-type: none"> <li>Dispensed by the physician in the office</li> </ul>		
<b>Cigna Telehealth Connection Services</b>	Plan pays 90%	Not Covered
<ul style="list-style-type: none"> <li>Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com)</li> <li>Telehealth services rendered by providers that are not contracted medical telehealth providers (as described on myCigna.com) are covered at the same benefit level as the same services would be if rendered in-person.</li> </ul>		
<b>Preventive Care</b>		
<b>Preventive Care</b> Birth through age 5	Plan pays 100%	PCP: Plan pays 70% Specialist: Plan pays 70%
Ages 6 and older	Plan pays 100%	PCP: After the plan deductible is met, your plan pays 70% Specialist: After the plan deductible is met, your plan pays 70%
<ul style="list-style-type: none"> <li>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.</li> </ul>		

Benefit	In-Network	Out-of-Network
<b>Immunizations</b> Birth through age 5  Ages 6 and older	Plan pays 100%  Plan pays 100%	PCP: Your plan pays 70% Specialist: Your plan pays 70% PCP: After the plan deductible is met, your plan pays 70% Specialist: After the plan deductible is met, your plan pays 70%
<b>Mammograms</b> <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul>	Plan pays 100%	Plan pays 100%
<b>PAP and PSA Tests</b> <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul>	Plan pays 100%	Plan pays based on place of service.
<b>Inpatient</b>		
<b>Inpatient Hospital Facility Services</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Semi-Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate <b>Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate <b>Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):</b> In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate		
<b>Inpatient Hospital Physician's Visit/Consultation</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Inpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Outpatient</b>		
<b>Outpatient Facility Services</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Outpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>	Plan pays 90%	After the plan deductible is met, your plan pays 70%

Benefit	In-Network	Out-of-Network
<b>Short-Term Rehabilitation - PCP</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Short-Term Rehabilitation - Specialist</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
Calendar Year Maximums: <ul style="list-style-type: none"> <li>Pulmonary Rehabilitation - 20 days</li> <li>Cognitive Therapy - 20 days</li> <li>Physical Therapy, Speech Therapy and Occupational Therapy – 60 days for each therapy</li> <li>Aural Therapy - 60 days</li> </ul>		
<b>Note:</b> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
<b>Chiropractic Care - PCP</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Chiropractic Care - Specialist</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
Calendar Year Maximum: <ul style="list-style-type: none"> <li>Chiropractic Care - Unlimited days</li> </ul>		
<b>Cardiac Rehabilitation - PCP</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Cardiac Rehabilitation - Specialist</b>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
Calendar Year Maximum: <ul style="list-style-type: none"> <li>Cardiac Rehabilitation – 36 days</li> </ul>		
<b>Note:</b> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
<b>Other Health Care Facilities/Services</b>		
<b>Home Health Care</b> (includes outpatient private duty nursing subject to medical necessity) <ul style="list-style-type: none"> <li>150 days maximum per Calendar Year(The limit is not applicable to mental health and substance use disorder conditions.)</li> <li>16 hour maximum per day</li> <li>Home Health Care Deductible will not exceed \$50 per individual</li> </ul>	Plan pays 100%	Your plan pays 75% after Home Health Care Deductible is met
<b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities</b> <ul style="list-style-type: none"> <li>120 days maximum per Calendar Year for Skilled Nursing Facility</li> <li>120 days maximum per Calendar Year for Rehabilitation Hospital and Sub-Acute Facility, Combined</li> </ul>	Plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Durable Medical Equipment</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> </ul>	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%

Benefit	In-Network	Out-of-Network
<b>Breast Feeding Equipment and Supplies</b> <ul style="list-style-type: none"> <li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician</li> <li>Includes related supplies</li> </ul>	Plan pays 100%	After the plan deductible is met, your plan pays 70%
<b>External Prosthetic Appliances (EPA)</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> </ul>	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Routine Foot Disorders</b> Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	Not Covered	Not Covered
<b>Hearing Aid</b> <ul style="list-style-type: none"> <li>Maximum of 2 devices per 36 months</li> <li>Includes testing and fitting of hearing aid devices at Physician Office Visit cost share.</li> </ul>	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Medical Specialty Drugs</b>		
<b>Inpatient</b> <ul style="list-style-type: none"> <li>This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.</li> </ul>	Your plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Outpatient Facility Services</b> <ul style="list-style-type: none"> <li>This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.</li> </ul>	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Physician's Office</b> <ul style="list-style-type: none"> <li>This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's Office. This benefit does not cover the related Office Visit or Professional charges.</li> </ul>	Your plan pays 90%	After the plan deductible is met, your plan pays 70%
<b>Home</b> <ul style="list-style-type: none"> <li>This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.</li> </ul>	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%

## Place of Service - your plan pays based on where you receive services

Note: Services where plan deductible applies are noted with a caret (^).

Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Laboratory</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 90%	Plan pays 70% ^	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 90%	Plan pays 70% ^
<b>Radiology</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 90%	Plan pays 70% ^
<b>Advanced Radiology Imaging</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Outpatient Facility Services	Covered same as plan's Outpatient Facility Services

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc.

Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit

Benefit	Emergency Room / Urgent Care Facility		Outpatient Professional Services		*Ambulance	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Emergency Care</b>	Plan pays 90%		Plan pays 90%		Plan pays 90% ^	
<b>Urgent Care</b>	Plan pays 90% ^		Plan pays 90% ^		Not Applicable*	

\*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Hospice</b>	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^
<b>Bereavement Counseling</b>	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^

Note: Services provided as part of Hospice Care Program

Benefit	Initial Visit to Confirm Pregnancy		Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)		Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)		Delivery - Facility (Inpatient Hospital, Birthing Center)			
	In-Network	Out-of- Network	In-Network	Out-of- Network	In-Network	Out-of- Network	In-Network	Out-of- Network		
Maternity	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 90%	Plan pays 70% ^	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit		
Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of- Network	In-Network	Out-of- Network	In-Network	Out-of- Network	In-Network	Out-of- Network	In-Network	Out-of- Network
Abortion (Elective and non-elective procedures)	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 90%	Plan pays 70% ^	Plan pays 90%	Plan pays 70% ^	Covered same as plan's Inpatient Professional Services	Covered same as plan's Inpatient Professional Services	Covered same as plan's Outpatient Professional Services	Covered same as plan's Outpatient Professional Services
Family Planning - Men's Services	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 90%	Plan pays 70% ^	Plan pays 90%	Plan pays 70% ^	Covered same as plan's Inpatient Professional Services	Covered same as plan's Inpatient Professional Services	Covered same as plan's Outpatient Professional Services	Covered same as plan's Outpatient Professional Services
Includes surgical services, such as vasectomy (excludes reversals)										
Family Planning - Women's Services	Plan pays 100%	Covered same as plan's Physician's Office Services	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Covered same as plan's Inpatient Professional Services	Plan pays 100%	Covered same as plan's Outpatient Professional Services
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										

Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Infertility</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 90%	Plan pays 70% ^	Plan pays 90%	Plan pays 70% ^	Covered same as plan's Inpatient Professional Services	Covered same as plan's Inpatient Professional Services	Covered same as plan's Outpatient Professional Services	Covered same as plan's Outpatient Professional Services
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. Unlimited maximum per lifetime										
<b>TMJ, Surgical and Non-Surgical</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 90%	Plan pays 70% ^	Plan pays 90%	Plan pays 70% ^	Covered same as plan's Inpatient Professional Services	Covered same as plan's Inpatient Professional Services	Covered same as plan's Outpatient Professional Services	Covered same as plan's Outpatient Professional Services
Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity. Unlimited maximum per lifetime										
<b>Bariatric Surgery</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 90%	Plan pays 70% ^	Plan pays 90%	Plan pays 70% ^	Covered same as plan's Inpatient Professional Services	Covered same as plan's Inpatient Professional Services	Covered same as plan's Outpatient Professional Services	Covered same as plan's Outpatient Professional Services
<b>Surgeon Charges Lifetime Maximum: Unlimited</b>										
Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: <ul style="list-style-type: none"> <li>medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity.</li> <li>weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision</li> </ul>										



Benefit	Inpatient Hospital Facility			Inpatient Professional Services		
	Cigna LifeSOURCE Transplant Network ® Facility In-Network	Non-LifeSOURCE Facility In-Network	Out-of-Network	Cigna LifeSOURCE Transplant Network ® Facility In-Network	Non-LifeSOURCE Facility In-Network	Out-of-Network
<b>Organ Transplants</b>	Plan pays 100%	Plan pays 90%	Plan pays 70% ^	Plan pays 100%	Covered same as plan's Inpatient Professional Services	Covered same as plan's Inpatient Professional Services

- Travel Lifetime Maximum - Cigna LifeSOURCE Transplant Network® Facility: In-Network: \$10,000 maximum per Transplant per Lifetime

Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Mental Health</b>	Plan pays 90%	Plan pays 70% ^	Plan pays 90%	Plan pays 70% ^	Plan pays 90%	Plan pays 70% ^
<b>Substance Use Disorder</b>	Plan pays 90%	Plan pays 70% ^	Plan pays 90%	Plan pays 70% ^	Plan pays 90%	Plan pays 70% ^

Note: Services where plan deductible applies are noted with a caret (^).

Notes:

- Unlimited maximum per Calendar Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes Individual, Intensive Outpatient, and Group Therapy; also Partial Hospitalization.
- Detox is covered under medical.

## Mental Health and Substance Use Disorder Services

### Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

#### Cigna Total Behavioral Health - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy	In-Network	Out-of-Network
<b>Cost Share and Supply</b>		
<b>Cigna Pharmacy Cost Share</b> <ul style="list-style-type: none"> <li>Retail – up to 31-day supply</li> <li>Home Delivery – up to 90-day supply (except Specialty up to 31-day supply)</li> </ul>	<b>Retail (per 31-day supply):</b> Generic: You pay \$10 Preferred Brand: You pay \$30 Non-Preferred Brand: You pay \$50  <b>Home Delivery (per 90-day supply):</b> Generic: You pay \$10 Preferred Brand: You pay \$30 Non-Preferred Brand: You pay \$50	<b>Retail:</b> Generic: You pay \$10 Preferred Brand: You pay \$30 Non-Preferred Brand: You pay \$50  <b>Home Delivery:</b> Not Covered
<ul style="list-style-type: none"> <li>Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation.</li> <li>Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.</li> <li>If a generic is available, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug.</li> <li>Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.</li> <li>Specialty Drugs provided at Home Delivery at the Retail (per 31-day supply) cost share.</li> </ul>		
<b>Drugs Covered</b>		
<b>Prescription Drug List:</b> Your Cigna Value Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. Some of the more expensive drugs are excluded when there are less expensive alternatives. To check which drugs are included in your plan, please log on to myCigna.com. Some highlights: <ul style="list-style-type: none"> <li>Coverage includes Self Administered injectables and optional injectable drugs – includes infertility drugs.</li> <li>Contraceptive devices and drugs are covered with federally required products covered at 100%.</li> <li>Insulin, glucose test strips, lancets, insulin needles &amp; syringes, insulin pens and cartridges are covered.</li> <li>Oral Fertility drugs are covered.</li> </ul>		

## Pharmacy Program Information

### Pharmacy Clinical Management: Essential

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

## Additional Information

### Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

### Healthy Pregnancies/Healthy Babies

- Care Management outreach
- Maternity Case Management
- Neo-natal Case Management

Included

## Additional Information

### Maximum Reimbursable Charge

Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentile (90th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. These charges are compiled in a database selected by Cigna. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance. Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

### Out-of-Network Emergency Services Charges

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

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

### Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:

- (a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
- (b) an Employee, a former Employee, an Employee's Dependent, or former 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.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

### 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.

### One Guide

Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

### Pre-Certification - Continued Stay Review - PHS Inpatient - required for all inpatient admissions

In-Network: Coordinated by your physician

Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance. Coverage is paid at 70%, not to exceed \$400 per admission, up to \$1,000 per Calendar Year applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission. Benefits are denied for any admission reviewed by Cigna Healthcare and not certified. Benefits are denied for any additional days not certified by Cigna Healthcare.

**Pre-Existing Condition Limitation (PCL)** does not apply.

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NY

PPO - Hawaii Plan

## Additional Information

### Your Health First - 200

Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

## Definitions

**Coinsurance** - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.

**Copay** - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

**Deductible** - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

**Out-of-Pocket Maximum** - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.

**Place of Service** - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

**Prescription Drug List** - The list of prescription brand and generic drugs covered by your pharmacy plan.

**Professional Services** - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists

**Transition of Care** - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

## Exclusions

### What's Not Covered (not all-inclusive):

Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.

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NY

PPO - Hawaii Plan

## Exclusions

- 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 use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
  - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
  - The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- 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.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Any medications, drugs, 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), anorgasm, 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 or condition 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.

## Exclusions

- 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.
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- 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.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- 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.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- 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.
- Massage therapy.

### These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate, service agreement or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

*All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.*

1/1/2020  
NY  
PPO - Hawaii Plan

EHB State: NY

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1/1/2020  
NY  
PPO - Hawaii Plan



# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

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

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

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file

a grievance by sending an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com) or by writing to the following address:

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, DC 20201  
1.800.368.1019, 800.537.7697 (TDD)  
Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. ATTENTION: If you speak languages other than English, language assistance services, free of charge are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

## Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Home Office: Bloomfield, Connecticut*

*Mailing Address: Hartford, Connecticut 06152*

**CIGNA HEALTH AND LIFE INSURANCE COMPANY**  
**a Cigna Company (called Cigna)**  
**CERTIFICATE RIDER**

No. HIMED2ET20

Policyholder: JPMorgan Chase & Co.

Rider Eligibility: Each Employee who is located in Hawaii

Policy No. or Nos. 3174696-HAWAII

EFFECTIVE DATE: January 1, 2020

You will become insured on the date you become eligible if you are in Active Service on that date or if you are not in Active Service on that date due to your health status.

This certificate rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified above. This rider replaces any other issued to you previously.

Additionally, the provisions identified in this rider only apply to:

- (a) Benefit plans made available to you and/or your Dependents by your Employer;
- (b) Benefit plans for which you and/or your Dependents are eligible;
- (c) Benefit plans which you have elected for you and/or your Dependents;
- (d) Benefit plans which are currently effective for you and/or your Dependents.

The provisions set forth in this certificate rider comply with the legislative requirements of Hawaii regarding group insurance plans covering insureds located in Hawaii. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.



HC-RDR117

10-17

## Preferred Provider Medical Benefits The Schedule

### For You and Your Dependents

#### 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 Deductibles, Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule.

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- 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 cross-accumulate between In- and Out-of-Network. All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Lifetime Maximum</b>	Unlimited	
<b>The Percentage of Covered Expenses the Plan Pays</b>	90%	70% of the Maximum Reimbursable Charge
<b>Calendar Year Deductible</b>		
Individual	\$100 per person	\$100 per person
Family Maximum	\$300 per family	\$300 per family
<b>Out-of-Pocket Maximum</b>		
Individual	\$2,500 per person	\$2,500 per person
Family Maximum	\$7,500 per family	\$7,500 per family

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Primary Care Physician's Services</b>		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Consultant and Referral Physician's Services		
<b>Note:</b> OB/GYN providers will be considered either as a PCP or Specialist.		
<b>Surgery Performed In the Physician's Office</b>		
Primary Care Physician	90%	Plan deductible, then 70%
Specialty Care Physician	90%	Plan deductible, then 70%
<b>Second Opinion Consultations (provided on a voluntary basis)</b>		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
<b>Allergy Treatment/Injections</b>		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
<b>Allergy Serum (dispensed by the Physician in the office)</b>		
Primary Care Physician	90%	Plan deductible, then 70%
Specialty Care Physician	90%	Plan deductible, then 70%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Preventive Care</b> Routine Preventive Care – all ages Primary Care Physician’s Office Visit Specialty Care Physician’s Office Visit Immunizations – all ages Primary Care Physician’s Office Visit Specialty Care Physician’s Office Visit	100% 100% 100% 100%	70%, for children through age 5, otherwise refer to your certificate 70%, for children through age 5, otherwise refer to your certificate 70%, for children through age 5, otherwise refer to your certificate 70%, for children through age 5, otherwise refer to your certificate
<b>Mammograms</b> Preventive Care Related Services (i.e. “routine” services) Diagnostic Related Services (i.e. “non-routine” services)	100% Subject to the plan’s x-ray benefit & lab benefit; based on place of service	Subject to the plan’s x-ray benefit & lab benefit; based on place of service Subject to the plan’s x-ray benefit & lab benefit; based on place of service
<b>Inpatient Hospital - Facility Services</b>	90%	Plan deductible, then 70%
<b>Outpatient Facility Services</b> Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	90%	Plan deductible, then 70%
<b>Inpatient Hospital Physician’s Visits/Consultations</b>	90%	Plan deductible, then 70%
<b>Inpatient Hospital Professional Services</b> Surgeon Radiologist Pathologist Anesthesiologist	90%	Plan deductible, then 70%
<b>Outpatient Professional Services</b> Surgeon Radiologist Pathologist Anesthesiologist	90%	Plan deductible, then 70%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Emergency and Urgent Care Services</b>  Hospital Emergency Room Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.  Urgent Care Facility or Outpatient Facility Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the UC visit.  Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER/UC visit  Emergency Room Care  Urgent Care  Ambulance	90%           Plan deductible, then 90%           90%  Plan deductible, then 90%  Plan deductible, then 90%	90%           Plan deductible, then 90%           90%  Plan deductible, then 90%  Plan deductible, then 90%
<b>Skilled Nursing Facility</b> Calendar Year Maximum: 100 days	90%	Plan deductible, then 70%
<b>Laboratory Services</b>  Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Outpatient Hospital Facility Independent Lab facility	90% 90% 90% 90%	Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70%
<b>Radiology Services</b>  Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Outpatient Hospital Facility	90% 90% 90%	Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</b> Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Inpatient Facility Outpatient Facility	90% 90% 90% 90%	Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70%
<b>Outpatient Short-Term Rehabilitative Therapy</b> Calendar Year Maximum: Unlimited Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Primary Care Physician's Office Visit Specialty Care Physician's Office Visit	90% 90%	Plan deductible, then 70% Plan deductible, then 70%
<b>Outpatient Cardiac Rehabilitation</b> Calendar Year Maximum: 36 days Primary Care Physician's Office Visit Specialty Care Physician's Office Visit	90% 90%	Plan deductible, then 70% Plan deductible, then 70%
<b>Chiropractic Care</b> Calendar Year Maximum: Unlimited Primary Care Physician's Office Visit Specialty Care Physician's Office Visit	90% 90%	Plan deductible, then 70% Plan deductible, then 70%
<b>Home Health Care</b> Calendar Year Maximum: 60 days (includes outpatient private nursing when approved as Medically Necessary)	100%	Plan deductible, then 75%



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Hospice</b> Lifetime Maximum: 120 days Inpatient Services Outpatient Services (same coinsurance level as Home Health Care)	 90% 100%	 Plan deductible, then 70% Plan deductible, then 75%
<b>Bereavement Counseling</b> Services Provided as part of Hospice Care Inpatient Outpatient Services Provided by Mental Health Professional	 90% 100% Covered under Mental Health benefit	 Plan deductible, then 70% Plan deductible, then 75% Covered under Mental Health benefit
<b>Maternity Care Services</b> Initial Visit to Confirm Pregnancy <b>Note:</b> OB/GYN providers will be considered either as a PCP or Specialist. Primary Care Physician's Office Visit Specialty Care Physician's Office Visit All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee) Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Delivery – Facility (Inpatient Hospital, Birthing Center)	 90% 90% 90%  90% 90% 90%	  Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70%  Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Women's Family Planning Services</b>		
Office Visits, Lab and Radiology Tests and Counseling		
<b>Note:</b> Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a Physician. Diaphragms also are covered when services are provided in the Physician's office.		
Primary Care Physician	100%	Plan deductible, then 70%
Specialty Care Physician	100%	Plan deductible, then 70%
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)		
Primary Care Physician's Office Visit	100%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	100%	Plan deductible, then 70%
Inpatient Facility	100%	Plan deductible, then 70%
Outpatient Facility	100%	Plan deductible, then 70%
Inpatient Professional Services Radiologist, Pathologist and Anesthesiologist	100%	Plan deductible, then 70%
Outpatient Professional Services Radiologist, Pathologist and Anesthesiologist	100%	Plan deductible, then 70%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Men's Family Planning Services</b>		
Office Visits, Lab and Radiology Tests and Counseling		
Primary Care Physician	90%	Plan deductible, then 70%
Specialty Care Physician	90%	Plan deductible, then 70%
Surgical Sterilization Procedures for Vasectomy (excludes reversals)		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Inpatient Facility	90%	Plan deductible, then 70%
Outpatient Facility	90%	Plan deductible, then 70%
Inpatient Professional Services Radiologist, Pathologist and Anesthesiologist	90%	Plan deductible, then 70%
Outpatient Professional Services Radiologist, Pathologist and Anesthesiologist	90%	Plan deductible, then 70%

BENEFIT HIGHLIGHTS		IN-NETWORK	OUT-OF-NETWORK
<b>Infertility Treatment</b> Coverage will be provided for the following services: <ul style="list-style-type: none"> <li>• Testing and treatment services performed in connection with an underlying medical condition.</li> <li>• Testing performed specifically to determine the cause of infertility.</li> <li>• Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).</li> <li>• Artificial Insemination, GIFT, ZIFT, etc.</li> <li>• In-vitro limited to 1 attempt per lifetime.</li> </ul>			
Physician's Office Visit (Lab and Radiology Tests, Counseling)			
Primary Care Physician	90%		Plan deductible, then 70%
Specialty Care Physician	90%		Plan deductible, then 70%
Inpatient Facility	90%		Plan deductible, then 70%
Outpatient Facility	90%		Plan deductible, then 70%
Inpatient Professional Services Radiologist, Pathologist and Anesthesiologist	90%		Plan deductible, then 70%
Outpatient Professional Services Radiologist, Pathologist and Anesthesiologist	90%		Plan deductible, then 70%
Lifetime Maximum for services other than In vitro: Unlimited			
Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).			

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Organ Transplant</b> Includes all medically appropriate, non-experimental transplants Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Inpatient Facility Inpatient Professional Services Radiologist, Pathologist and Anesthesiologist Lifetime Travel Maximum: \$10,000 per transplant	90% 90% 100% at Lifesource center, otherwise Plan deductible, then 90% 100% at Lifesource center, otherwise Plan deductible, then 90% 100% (only available when using Lifesource facility)	Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70% In-Network coverage only
<b>External Prosthetic Appliances</b> Calendar Year Maximum: Unlimited	90%	Plan deductible, then 70%
<b>Nutritional Evaluation</b> Calendar Year Maximum: 3 visits per person, however the 3 visit limit will not apply to treatment of diabetes. Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Inpatient Facility Outpatient Facility Inpatient Professional Services Radiologist, Pathologist and Anesthesiologist Outpatient Professional Services Radiologist, Pathologist and Anesthesiologist	90% 90% 90% 90% 90% 90%	Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70%
<b>Nutritional Formulas</b> Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 70%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Obesity/Bariatric Surgery</b> <b>Note:</b> Coverage is provided subject to Medical Necessity and clinical guidelines subject to any limitations shown in the “Exclusions, Expenses Not Covered and General Limitations” section of the certificate. Primary Care Physician’s Office Visit Specialty Care Physician’s Office Visit Inpatient Facility Outpatient Facility Inpatient Professional Services Radiologist, Pathologist and Anesthesiologist Outpatient Professional Services Radiologist, Pathologist and Anesthesiologist Surgical Professional Services Lifetime Maximum: Unlimited	90% 90% 90% 90% 90% 90%	Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70%
<b>Mental Health</b> <b>Inpatient</b> <b>Outpatient (Includes Individual, Group and Intensive Outpatient)</b> Physician’s Office Visit Outpatient Facility	90% 90% 90%	Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70%
<b>Substance Abuse</b> <b>Inpatient</b> <b>Outpatient (Includes Individual and Intensive Outpatient)</b> Physician’s Office Visit Outpatient Facility	90% 90% 90%	Plan deductible, then 70% Plan deductible, then 70% Plan deductible, then 70%

## Medical Care Benefits

### THE SCHEDULE

#### 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.

When PAC is not received prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission, the following penalty will be applied:

- Covered Expenses incurred will be paid at 70%, until a maximum penalty of \$400 per admission or \$1,000 per calendar year is reached.

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.

## Eligibility – Effective Date

### Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you work at least 20 hours a week for 4 consecutive weeks.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any Waiting Period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

**Initial Employee Group:** You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees, as determined by your Employer.

**New Employee Group:** You are in the New Employee Group if you are not in the Initial Employee Group.

### Change in Family Status

You may possibly be eligible to change your original selection of benefits when a change in your family status occurs. Consult your Employer for details.

### Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

### Waiting Period

**Initial Employee Group:** None

**New Employee Group:** 20 hours a week for 4 consecutive weeks

### Classes of Eligible Employees

Each Employee who is located in Hawaii

### Effective Date of Employee Insurance

You will become insured on the next enrollment date after you complete the waiting period.

### Late Entrant

Not applicable

### Covered Expenses

- charges for Medically Necessary diabetes supplies, equipment, and education when prescribed by a health care professional authorized to prescribe these benefits. Self-management and education visits will be treated the same as any other office visit.
- charges for contraceptive services and prescription contraceptives. Contraceptive services are those intended to promote effective use of prescription as well as nonprescription contraceptive supplies and devices to prevent unwanted pregnancy. These services and supplies must be provided by a Physician, Physician's assistant,

nurse practitioner, certified nurse midwife, nurse, or a person supervised by a Physician.

- charges for Mental Health which is defined as a syndrome of clinically significant psychological, biological, or behavioral abnormalities that result in personal distress or suffering, impairment of capacity for functioning, or both as defined in the most recent publications of the:
  - Diagnostic and Statistical Manual of the American Psychiatric Association (DSM), or the
  - International Classification of Disease
- charges for the use of telecommunications services and enhanced services to deliver health care and information to parties separated by distance. Telehealth benefits include a Hospital's angiogram transmission to another medical facility; x-ray transmissions from one island to another; emergency room consultation between a Hospital and a medical center; and telehealth facilities at a medical center. It does not include standard telephone and/or fax transmissions in the absence of other integrated information and data.
- charges for screening by low-dose mammography for occult breast cancer to include: an annual mammogram for women forty and older; and an annual mammogram for women at any age if there is a history of breast cancer present for her, her mother or her sister and if a test is ordered by her Physician.
- charges for medical foods and low protein modified food products for the treatment of an inborn error of metabolism provided they are prescribed as Medically Necessary for the therapeutic treatment of an inborn error of metabolism and are consumed or administered enterally under the supervision of a licensed Physician.
  - an inborn error of metabolism is a disease caused by an inherited abnormality of the body chemistry of a person that is characterized by deficient metabolism, originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate, or fat. Low protein modified food products are food products that are specially formulated to have less than one gram of protein per serving; are prescribed or ordered by a Physician as Medically Necessary for dietary treatment of an inborn error of metabolism; and do not include a food that is naturally low in protein. Medical foods are foods that are formulated to be consumed or administered enterally under the supervision of a Physician and are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below for a

Dependent child who is age 5 or less for charges made for Child Health Supervision 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 Health Supervision Services at each of the Approximate Age Intervals up to a total of 12 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 Health Supervision 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 and 5 years.

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

#### **Infertility Services**

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician, approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-



reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and the services of an embryologist.

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

However, the following are specifically excluded infertility services:

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

## **Exclusions, Expenses Not Covered and General Limitations**

Any exclusions in your certificate for the following are **NULL and VOID**:

- pre-existing conditions;
- acts of war, riot or insurrection;
- telemedicine;
- family members who provide a service, therapy or treatment intended primarily to improve or maintain general physical condition;
- treatment denied by the Medicare Plan or a Primary Plan; or
- Home Health Services and Hospice Services not including 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.

The following exclusions are added to your certificate:

- Home Health Services and Hospice Services do not include services by a person who is a parent, child or spouse who normally resides in your house or your Dependent's house.
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs

or treatments, whether prescribed or recommended by a Physician or under medical supervision.

## **Termination**

### **Termination of Insurance - Employees**

Your insurance will cease on the earliest date below:

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

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

### **Temporary Layoff or Leave of Absence**

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

### **Injury or Sickness**

If your Active Service ends due to an Injury or Sickness, your insurance will be continued for at least 3 months following the month of disability while you remain totally and continuously disabled as a result of the Injury or Sickness. However, after this period of 3 months, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

## **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 Customer Service**

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

We will do our best to resolve the matter on your initial contact. If you are not satisfied with the results of a coverage decision, you can start the Appeals Procedure.

### **Internal Appeals Procedure**

Cigna has a one step appeal 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, to the following address:

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

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

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

We will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision) or for appeals involving Medical Necessity. We will respond within 60 calendar days after we receive a postservice administrative appeal. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

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

You may request that the appeal process be expedited if, 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 your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

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

Cigna'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.

Cigna will send notice of its final internal determination to you, your appointed representative, if applicable, your treating provider, and the commissioner. The notice shall include the following information regarding your rights and procedures:

- your right to request an external review;
- the deadline for requesting an external review;
- instructions on how to request an external review; and
- where to submit the request for an external review.

### **Independent Review Procedure**

If you are not fully satisfied with the decision of Cigna's 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 this level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is a charge for you to initiate this independent review process. Cigna 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 Cigna. 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 130 days of your receipt of Cigna's appeal review denial. Cigna will within 5 business days after receipt of the request then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and when a delay would be detrimental to your condition, as determined by Cigna's Physician Reviewer, the review shall be completed within 72 hours.

## Notice of Benefit Determination on Appeal

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

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

## Relevant Information

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

## Legal Action

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

action will be brought at all unless brought within three years after a claim is submitted for In-Network services or within three years after proof of claim is required under the Plan for Out-of-Network services.

## 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 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.

### Dependent

The following are considered Dependents under this plan:

- any adopted child or a child placed for adoption. This means the assumption and retention of a legal obligation for total or partial support in anticipation of the adoption of the child.

### Employee

The term Employee means an Employee of the Employer who works at least 20 hours a week for 4 consecutive weeks.

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