Summary Plan Description and Plan Document:

Cigna Medical Plan

HSA Options

EFFECTIVE DATE: JANUARY 1, 2018

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INTRODUCTION

The Cigna Medical Plan (Plan) is an employer-sponsored health and welfare employee benefit plan. It is designed to help you stay healthy and cover you around the clock when you need care. You can receive benefits for preventive screenings, routine care, hospitalization and surgery.

The Cigna Medical Plan offers you a choice of several different options for coverage and payment of medical care benefits. This is the Summary Plan Description (SPD) for the Health Savings Account options under the Cigna Medical Plan (HSA options). Other Cigna Medical Plan options are described in other SPDs that are available on the *Your Cigna Life* website (under *Self Service*). This document, along with the other Cigna Medical Plan SPDs, also serves as the Plan document for the Cigna Medical Plan.

Each of the HSA options combines a high deductible health plan medical coverage option and a special tax-advantaged savings account. The charts in Appendix I show the HSA options that are available for you to choose from and explain how the account works. Although we refer to the "Cigna Medical Plan," "Medical Plan" or "Plan" throughout this document, any references to coverage and exclusions in this SPD should be read to apply only to the HSA options under the Cigna Medical Plan. If you are enrolled in one of the Cigna Medical Plan's HSA options, you should take some time to review this document and keep it as a reference.

Benefit Chart At-A-Glance

The Benefit Chart At-A-Glance in Appendix I show the HSA options that are available for you to choose from and explain how the account works. This Chart is also available on the *Your Cigna Life* website. The Chart is part of this SPD and you should refer to the version of the Chart available on the website for the most up to date information about your benefits.

You will notice that certain terms are printed in **bold** throughout the document. They are defined in the "GLOSSARY".

Throughout this document, "you" refers to both you and your **covered dependents** unless the context indicates that it means you as an employee. This SPD provides details on:

- Eligibility, enrollment and costs,
- What's covered,
- What's not covered,
- How to access care,
- Coordination of benefits,
- Claims,
- The appeals process, and
- COBRA and **ERISA** rights.

Cigna Corporation changes the Plan from time to time. You will be notified about Plan changes through SPD updates, announcements and information on the *Your Cigna Life* website and written correspondence.

If you have any questions about the Medical Plan or the HSA options, see "WHO TO CONTACT" on page 2.

WHO TO CONTACT

The *Your Cigna Life* website has information about the Cigna Medical Plan and how to get the most from your Plan coverage. If you need more help, use the following chart to find out who to call for answers to questions about the Plan.

For More Information About…	Contact…
• Initial enrollment • Enrollment changes • Verification of coverage • Life status changes • Eligibility information • Health care coverage continuation (COBRA) general information • Direct billing	Your Cigna Life Service Center P.O. Box 62825 Phoenix, AZ 85082 1.800.551.3539 FAX: 855.674.5282 E-mail: YCLServiceCenter@Cigna.com
• Plan coverage and benefit information • Claims • Healthy Life Personal Health Team • Prescriptions/Cigna Home Delivery Pharmacy • Employee Assistance Program • Prior Authorization/Certification	Cigna Customer Service Center 1.888.99Cigna (1.888.992.4462) Email: Use the myCigna.com e-mail box
• COBRA (health care coverage continuation) administration	CONEXIS, a division of WageWorks P.O. Box 223684 Dallas, TX 75222-3684 1.888.678.4881
• Health Savings Account	Cigna Customer Service Center 1.888.99Cigna (1.888.992.4462) Email: Use the myCigna.com e-mail box

ELIGIBILITY

Who Is Eligible

You are eligible for Cigna Medical Plan coverage on your first day of employment as a **regular employee** of **Cigna**. If you are not a **regular employee** of Cigna, you may also be eligible to for Cigna Medical Plan coverage if the Plan Administrator determines, in its sole discretion, that it is necessary for you to be eligible for the Cigna Medical Plan for Cigna to avoid penalties under section 4980H of the Internal Revenue Code of 1986, as amended (the "Code").

You will receive information about all the Cigna Medical Plan options that are available to you, including the HSA options, when you first become eligible and then during annual benefits open enrollment periods.

To be eligible to open an HSA account under the HSA option of the Medical Plan you:

- Must be enrolled in an IRS-qualified, high-deductible health plan;
- Cannot have any other health coverage that is not a high-deductible health plan;
- Cannot be claimed as a dependent on another person's tax return;
- Must not be enrolled in Medicare (Part A, B or D), TRICARE, or a Flexible Spending Account that is not limited purpose (including a spouse's FSA).

Who Can Be Covered

You may choose Medical Plan coverage for:

- Yourself only;
- Yourself and your **spouse** or **partner**;
- Yourself and your **eligible dependent** children with no **spouse** or **partner**; or
- Yourself and your **spouse** or **partner** and your **eligible dependent** children.

The **plan administrator** has the right to require proof from you at any time of the eligibility of anyone you claim as an **eligible dependent**.

*Generally, if you are regularly scheduled to work less than 33 hours per week, you may only cover your **spouse** or **partner** if you and your **spouse** or **partner** were enrolled in the Plan in 2013.

*If you are a **legacy QANI employee** and are regularly scheduled to work at least 24 but less than 33 hours per week, you may only cover your **spouse** or **partner** if you and your **spouse** or **partner** were enrolled in the Plan before January 3, 2016.

COSTS

Your Cost

You and **Cigna** share in the cost of Medical Plan coverage. **Cigna** pays for the benefits provided by the Plan from its general assets, subject to the limitations described in this SPD, and except to the extent that participant contributions are required.

Your **payroll cost** is the part of your share of the Plan cost that you pay with pre-tax dollars through payroll deductions – **pre-tax contributions**. (If you work in Puerto Rico, you make after-tax contributions.)

The amount of your **payroll cost** depends on the Medical Plan option you choose, which network you choose, who you cover and whether you are a full-time or part-time employee. **Payroll costs** for part-time employees who are regularly scheduled to work less than 33 hours per week are higher than the **payroll costs** for full-time employees and part-time employees regularly scheduled to work more than 33 hours per week because **Cigna** provides a larger company subsidy for these employees.

See the *Your Cigna Life* website for **payroll cost** information for the current Cigna Medical Plan options. You will receive **payroll cost** information for the upcoming **plan year** during the annual enrollment period.

You may also pay part of your share of the Plan's cost through **deductibles** and **coinsurance**.

Healthy Life Incentives

When you enroll in the Medical Plan, you may qualify for certain Healthy Life Incentives that are added to your paychecks during the **plan year**.

See Appendix II for information about the Healthy Life Incentives that are currently available and the requirements that apply to earn them.

ENROLLMENT

When and How You Enroll

Except as described in the During the Annual Enrollment Period section below, you are not covered automatically and must enroll to have Plan coverage. There are four occasions when you can enroll:

- When you become a **regular employee**;
- During any annual enrollment period;
- After you have a **life status change**; or
- When you have special enrollment rights.

If You Are Newly Eligible

You become eligible for Medical Plan coverage on your first day of employment as a **regular employee**. This is the date you are hired or rehired, or the date your employment classification changes to **regular employee** status.

You have 30 days after the date you first become eligible for Medical Plan coverage to elect and enroll in a Medical Plan option. If you do enroll, your coverage is effective from the first day you are eligible; for example, if your hire date as a **regular employee** is March 15 and you enroll on April 1, your coverage begins as of March 15. Your **payroll cost** contributions will start to be deducted from your paycheck in the first pay processed after you make your election. If you do not enroll within 30 days of your date of hire, you cannot enroll in the Plan until the next annual enrollment or if you experience a **life status change** event. See the "If You Have a Life Status Change" section of this SPD for further details.

You can find information about the Medical Plan and enrolling online through the *Your Cigna Life* website *(Health & Well-Being>Benefits Enrollment*). To enroll, follow the instructions in the online enrollment materials.

During the Annual Enrollment Period

If you are a **regular employee**, you can enroll in the Medical Plan during the annual enrollment period. The coverage you elect during annual enrollment is effective the following January 1 for the entire **plan year**.

During the annual enrollment period, you may make changes to your Plan elections. For example, you may:

- Add, drop or change your medical coverage; or
- Increase or reduce the number of **eligible dependents** you enroll for medical coverage.

Once the enrollment period ends, you cannot change your election until the next annual enrollment period or until you have a qualified **life status change**. However, you may be allowed to change your election after the end of the enrollment period but before the beginning of the new **plan year** if the **plan administrator** determines that, due to unusual circumstances, the enrollment period deadline creates a hardship for you.

If you are enrolled in the Plan and do not make an election at the annual enrollment period for the next **plan year**, you will be automatically enrolled for the next **plan year** in your coverage elections currently in effect (subject to any changes made to the Plan).

You can find information about enrollment in the Cigna Medical Plan, at or before the beginning of the annual enrollment period, online through the *Your Cigna Life* website. To enroll in the Plan, follow the instructions in the online enrollment materials.

If You Have a Life Status Change

You can enroll in the Medical Plan outside the annual enrollment period if you have a qualifying **life status change**. To enroll in the Plan on account of a **life status change**, you must request a coverage change within 30 days after the qualifying **life status change** event by going to the *Life Events* section of the *Your Cigna Life* website (*Self Service>Employee Self Service>Life Events*) or contacting the Your Cigna Life Service Center at 1.800.551.3539. You may enroll in the Medical Plan when you have a **life status change** only if your enrollment is due to and consistent with the **life status change** event.

Special Enrollment Rights

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**), you will be able to enroll yourself and your **eligible dependents** in the Medical Plan outside the annual enrollment period under circumstances that trigger special enrollment rights. Some of these circumstances are also **life status change** events:

- You previously declined enrollment in the Medical Plan for yourself or your **eligible dependents** because you had other health insurance or group health plan coverage and either (1) you or your **eligible dependents** lose eligibility for that other coverage, (2) the employer or policyholder stops contributing towards that other coverage, or (3) in the case of COBRA continuation coverage, the coverage ended.

  In this situation, to have Medical Plan coverage for yourself or your **eligible dependent**, you must enroll or add the dependent within 30 days after the event that triggers special enrollment rights (that is, after the other coverage ends or the employer or policyholder stops contributing). If you enroll on time, your Plan coverage will be effective on the event date. Failure to notify **Cigna** of your loss of coverage under your other health insurance or group health plan within 30 days will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period.

- You add a dependent due to marriage, birth, adoption, or placement for adoption, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Coverage added due to marriage, birth, adoption or placement for adoption will become effective as of the date of the event. Failure to notify **Cigna** of your marriage, birth, adoption, or placement for adoption within 30 days of the event will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period.

- You or an eligible dependent (1) loses health care coverage that you had under Medicaid or a state children's health insurance program (CHIP) because you are no longer eligible, or (2) becomes eligible for premium assistance under Medicaid or a state CHIP plan that subsidizes your payroll contributions for medical coverage.

  In this situation, to have Medical Plan coverage for you or your dependent, you must enroll or add the dependent within 60 days after the special enrollment rights trigger event (losing Medicaid or CHIP coverage or qualifying for premium assistance). If you enroll on time, your Plan coverage will be effective on the event date. Failure to notify **Cigna** of your loss or gain of eligibility for coverage under Medicaid or a state children's health plan within 60 days will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period.

To enroll in the Medical Plan on account of an event covered by special enrollment rights, you must, within 30 days of the event, go to the *Life Events* section of the *Your Cigna Life* website (*Self Service>Employee Self Service> Life Events*) or contact the Your Cigna Life Service Center at 1.800.551.3539 to complete the enrollment for you. If you are enrolling in

the Plan due to a change in your or your dependent's status under Medicaid or CHIP more than 30 days after the event, you must contact the Your Cigna Life Service Center at 1.800.551.3539 to complete the enrollment for you.

Enrolling Dependents

If you enroll yourself in the Medical Plan, you may also enroll anyone who qualifies as your eligible dependent, including your **spouse/partner** and your child under age 26. If you are enrolling a child for whom you are a legal guardian or a child who is being placed with you for adoption, you must submit proof of this relationship to the Your Cigna Life Service Center. The child's enrollment will be processed once proof of **eligible dependent** status is received and accepted by the Your Cigna Life Service Center. Coverage is retroactive to the event date.

If you wish to elect coverage for your **partner** and/or your **partner's** children, you must submit a notarized copy of a completed **Affidavit of Domestic Partnership** and required documentation to the Your Cigna Life Service Center. The enrollment will be processed once the Affidavit and required documentation is received and accepted by the Your Cigna Life Service Center. Coverage is retroactive to the event date.

Enrolling Newborn Children

Coverage for your newborn child is automatic for the first 30 days from the date of birth. In order for coverage for your newborn child to continue after the first 30 days, you must enroll your newborn child in the Medical Plan during this 30-day period, using the self-service tools on the *Life Events* section of the *Your Cigna Life* website (*Self Service>Employee Self Service>Life Events*) or you must call the Your Cigna Life Service Center at 1.800.551.3539. If you do not enroll an eligible newborn child within 30 days of birth, your newborn's coverage will terminate at the end of 30 days and you will not be able to enroll your child until the earlier of the next open enrollment period or, depending on the circumstances, another **life status change**.

Note: A child born to your female **covered dependent** child is NOT covered under the Medical Plan for other than routine **hospital** nursery care, unless the newborn is legally adopted by you and legally and financially dependent on you for support.

EVENTS AFFECTING YOUR PLAN COVERAGE, ELIGIBILITY OR COSTS

The information that follows describes events that may affect your Medical Plan coverage, eligibility or costs.

If You Have a Life Status Change

You can change or cancel certain Medical Plan coverage elections outside the annual enrollment period if you have a qualifying **life status change**.

You will be permitted to change your election based on the following events if, in the determination of the **plan administrator**, the change satisfies the requirements set forth in IRS regulations governing mid-year changes in election:

- You marry, divorce or have an annulment or a legal separation;
- You enter into or end a partnership;
- You have a new **eligible dependent** child by marriage, birth, adoption, placement for adoption, or legal guardianship;
- Your **eligible dependent** dies (including your **spouse**);
- Your or your **eligible dependent's** employment starts or terminates;
- You or your **eligible dependent** changes work location or residence, but only if it results in the need to change health care networks as determined by **Cigna**;
- You or your **eligible dependent** has a reduction or increase in hours of employment (including a switch between full-time and part-time status), the beginning or ending of an unpaid leave of absence, a strike or a lockout); or

- Your dependent satisfies or ceases to satisfy the requirements for **eligible dependent** status because of age, financial dependency, or any similar circumstances as provided under the Medical Plan.

In addition, you may be allowed to change your election based on the following events in the sole discretion of the **plan administrator,** and/or as legally required:

- Your **spouse** experiences a significant change in his or her group medical coverage;
- Service of a Qualified Medical Child Support Order (**QMCSO**) issued under **ERISA** Section 609, as approved by the **plan administrator**;
- Eligibility to participate in a government-sponsored premium assistance program; and
- Enrollment in Medicare or Medicaid (or loss of eligibility for Medicare or Medicaid).

To make a change in your Medical Plan coverage within 30 days after a qualifying **life status change** event, you must go to the *Life Events* section of the *Your Cigna Life* website (*Self Service>Employee Self Service>Life Events*) or contact the Your Cigna Life Service Center at 1.800.551.3539 for assistance. The change will take effect on the date of the **life status change** event and any necessary payroll deduction contribution changes will be made during the next available payroll processing cycle.

If you experience any of the **life status change** events noted above, any changes to your benefit selections must be on account of and correspond with a change in status that affects eligibility under the Plan. This means that you can make only those changes that directly relate to the event and are consistent with the event. For example, if you get divorced, you must delete your **spouse** from the Plan, but may not delete your dependent. Permissible election changes on account of a **life status change** event are:

- Elect, cancel or change medical coverage; or
- Add or delete **eligible dependents**.

If you are on an approved unpaid leave of absence (other than a family and medical leave) when you have a **life status change** event, you may change your election only if:

- You have or adopt a child -- then you may add the child to your coverage;
- You marry or enter a **partnership** -- then you may add your **spouse** or **partner** to your coverage;
- You get a divorce or annulment or end a **partnership** – then you may remove your **spouse** or **partner** from your coverage; or
- Your **eligible dependent** dies – then you may change your coverage tier, if appropriate.

All your other Medical Plan elections continue, unless they are no longer available, until you return to work.

If The Plan Has a Change in Cost or Coverage

If the cost or coverage of a Medical Plan option changes, the **plan administrator** may allow each affected participant to change his or her election during the **plan year**, subject to applicable legal requirements.

If You Are Enrolling a Dependent Who Has a Special Enrollment Right

You can change certain Medical Plan coverage elections outside of the open enrollment period when you enroll an **eligible dependent** with a special enrollment right.

See “Special Enrollment Rights” above for more information on special enrollment rights.

If You Are Eligible for Coverage Under Another Medical Plan with a Different Plan Year

You can change certain Cigna Medical Plan coverage elections outside of the open enrollment period if you have an **eligible dependent** who is also eligible for coverage under another employer’s medical plan -- but only if that medical

plan has a **plan year** that is not the calendar year and your Cigna Medical Plan election change is on account of and corresponds with a coverage change made by your **eligible dependent** under the other plan. To change your coverage election, contact the Your Cigna Life Service Center at 1.800.551.3539 within 30 days of the event.

If You Are Subject to a Qualified Medical Child Support Order

The Plan will comply with the terms of a **QMCSO**. If you are subject to a **QMCSO**, your noncustodial child will be enrolled as an **eligible dependent** (and, if you are not already covered under the Cigna Medical Plan, you will also be enrolled for coverage.) You must continue your Plan coverage while the **QMCSO** is in effect.

If your **eligible dependent** child is enrolled for Cigna Medical Plan coverage, and a **QMCSO** is issued requiring another individual to provide medical plan coverage for the child and that coverage is provided, you may make a change to cancel Cigna Medical Plan coverage for the child. To do so, you must send, fax or e-mail a copy of this **QMCSO** to the Your Cigna Life Service Center, who will update your election for you. See "WHO TO CONTACT" on page 2 for the address and fax number of the Your Cigna Life Service Center.

If you have questions about or wish to obtain a copy of the procedures governing a **QMCSO** determination (at no charge), contact the **plan administrator.**

If You Move

If you move, you must update your personal information on the *Your Cigna Life* website under *Self Service>Employee Self Service*. You will then be sent instructions for changing your medical coverage option only if you move to an area where there is no network access or a different network option applies, as determined by Cigna.

If Your Employment Status Changes

If your employment status changes from regular full-time to regular part-time, or vice versa, or if you are a regular part-time employee and the number of hours you are regularly scheduled to work changes from less than 33 to 33 or more or vice versa, the cost for your Medical Plan coverage will change automatically.

If your employment status changes from **regular employee** to anything else, you will no longer be eligible for Medical Plan coverage, but you will be offered COBRA coverage.

If your employment status changes from an ineligible status to **regular employee**, you will be eligible to enroll in the Medical Plan. In that case or if you otherwise become eligible to enroll in the Medical Plan, you will automatically be provided enrollment materials and instructions on how to enroll.

If You Become Eligible for Marketplace Coverage

You may change your election to drop your medical coverage if, in the determination of the Plan Administrator, you satisfy the requirements set forth in Notice 2014-55:

- You are eligible for a special enrollment period to enroll in a qualified health plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or you seek to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period; and
- The revocation of the election of coverage under the Plan corresponds to your (and any related individuals who cease coverage during the revocation's) intended enrollment in a qualified health plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of coverage under the Plan.

If You Take a Leave of Absence

During a paid leave of absence, you continue to make Medical Plan **payroll cost** contributions through payroll deduction.

During an approved unpaid leave of absence, including an unpaid **FMLA leave** (unless you elect otherwise), you will be billed monthly on an after-tax basis for your Medical Plan contributions. You will have a 31-day grace period following

the due date to make payment and your Medical Plan coverage will continue as long as you make the required contributions. If you do not make the required contributions before the end of the grace period, or you stop payments at any time during the leave, your Medical Plan coverage will end on the last day of the month for which you make the required contributions, and you will not be able to enroll for Medical Plan coverage again while you remain on leave.

Alternatively, with respect to approved unpaid **FMLA leave** only, you may elect to continue Medical Plan coverage and suspend **payroll cost** payments until you return to active employment. You must make this election before the start of your leave. When you return to active employment, your **payroll cost** will be adjusted to cover the amount of missed payments during your leave. If you fail to return to active employment, you will be billed for the amount of missed payments.

If you continue to be eligible for an approved leave of absence in a new calendar year, you may change your coverage election during the annual enrollment period. If you do not change your coverage election during annual enrollment, your current Medical Plan election will automatically continue in the new calendar year (to the extent it is still available) if you continue to make the required contributions.

- If you return to work as an active employee and you continued to make payments during your leave, your Medical Plan elections will automatically continue unless you request a change based on a **life status change**.
- If you return to work as an active employee and you did not continue to make payments during your leave, you may reinstate your Medical Plan coverage within 30 days of your return based on the rules that apply to a **life status change**.

The maximum period of a leave of absence for any reason is 30 months. If, at the end of 30 months of leave of absence, you have not returned to active employment, your **Cigna** employment will be terminated. See "If Your Cigna Employment Ends" for the effect of a termination of employment on your Medical Plan coverage.

If You Take a Disability Leave

Generally, you will be on a disability leave of absence during any period when you are eligible to receive benefits under either the Cigna Short-Term Disability Plan (STD) or Cigna Long-Term Disability Plan (LTD). During a disability leave, the Leave of Absence rules described above apply. Any period that you receive STD benefits is treated as a paid leave of absence, and any period that you receive LTD benefits is treated as an unpaid leave. On December 31 following the date you first receive benefits under the Cigna Long-Term Disability Plan, your eligibility for coverage under this Plan will end. You may be eligible for medical coverage under the Cigna Medical Plan for Retirees, Survivors and Disabled Employees. For details, see that plan's SPD.

If You Take a Military Leave of Absence

Generally, a paid or unpaid military leave (see *Military Leave* in the *Returns & Rewards* section on the *Your Cigna Life* website) is a leave of absence. If you are on a paid military leave of absence, your coverage will continue if you continue to make Medical Plan **payroll cost** contributions through payroll deduction or direct billing. If you are on an unpaid military leave of absence, the Leave of Absence rules for unpaid leave (described above) will apply.

If Your Cigna Employment Ends

Cigna Medical Plan coverage ends on the last day of the month of your termination of employment. If you are enrolled in the Medical Plan on your **termination of employment date**, you may elect to continue Medical Plan coverage under COBRA. You will find more information about COBRA under "COBRA Continuation Coverage".

If you are eligible for severance benefits from **Cigna** you will also be eligible for a **Cigna** subsidy for part of your COBRA coverage. **Cigna** will pay 65% of the cost of your COBRA Medical Plan coverage during the period you receive biweekly severance payments. You will be billed for the other 35% of the cost. If you continue your COBRA coverage after biweekly severance payments end, you will be billed for the full cost of COBRA coverage at unsubsidized rates, plus a 2% administration fee for the remainder of the COBRA period.

If you are not eligible for severance benefits from **Cigna**, you will be billed for the full cost of COBRA coverage at unsubsidized rates, plus a 2% administration fee.

If you do elect COBRA coverage:

- You will have the opportunity to change coverage options during the COBRA annual enrollment period.
- You will receive a new Medical Plan ID card for COBRA coverage. DESTROY THE OLD CARD.

If You Retire from Cigna

If you were first hired by **Cigna** before January 1, 2011, and you retire from **Cigna**, you may be eligible for **Cigna**-sponsored medical coverage beginning as early as the first day of the month following your **termination of employment date**. For details on the Cigna Medical Plan for Retirees, Survivors and Disabled Employees, see that plan's SPD.

If You Die While Employed

Cigna Medical Plan coverage ends on the last day of the month in which you die. Your **covered dependents** may elect COBRA coverage for up to 36 months at company-subsidized rates. COBRA coverage is explained under "COBRA Continuation Coverage". There are no Medical Plan conversion rights available.

In certain limited cases, if you die while employed, your **covered dependents** may also be eligible for medical coverage under the Cigna Medical Plan for Retirees, Survivors and Disabled Employees. For details, see that plan's SPD.

If You Change Cigna Medical Plan Options

If you change Medical Plan options during an annual enrollment period or because of a **life status change** or special enrollment right, the following rules apply:

- The new option generally will cover only treatment you or your **covered dependent** receives after the effective date of the option change.
- If you or your **covered dependent** is in the **hospital** when the new option becomes effective, your old option continues to apply to the **hospital** and related expenses you incur after the new option effective date while you are in the **hospital**, but your new option will apply to expenses that are not related to the hospitalization.
- The new option will apply to any expenses you incur after you or your **covered dependent** is released from the **hospital**.
- For purposes of your **deductible** and **out-of-pocket maximum**, expenses that you have incurred before the change will be credited to the new option.
- Your HSA contribution amounts will be adjusted accordingly.

WHEN YOUR MEDICAL COVERAGE ENDS

Your Medical Plan coverage ends automatically on December 31 of a **plan year** if your coverage option is no longer available in the following **plan year or** if you decline coverage during the annual enrollment period. In addition, if you are receiving LTD benefits, Medical Plan coverage ends on December 31 of the **plan year** in which LTD benefits are first paid to you.

Your Cigna Medical Plan coverage ends on the last day of the month during which one of these events occurs:

- You have a qualified **life status change** and choose to cancel coverage within 30 days after the qualifying event, if cancellation is consistent with the **life status change** event;
- You fail to make required **payroll cost** payments;
- You transfer from **regular employee** status to an ineligible status;

- Your **covered dependent** is no longer an **eligible dependent** (coverage ends only for the no-longer-**eligible-dependent**);
- Your **Cigna** employment terminates (including on account of retirement); or
- **Cigna** terminates the Cigna Medical Plan.

If you or a **covered dependent** is totally disabled and in the **hospital** when Medical Plan coverage ends, **hospital** benefits for the ongoing confinement will continue for the injury or illness that required this confinement until you or your **covered dependent** is released from the **hospital**. There is no Plan coverage after the release from the **hospital**.

Events That May Cause Cigna to Cancel Your Cigna Medical Plan Coverage

Cigna may cancel or terminate your Cigna Medical Plan coverage for any of these reasons:

- You provide false material information-
  - During enrollment or after a **life status change** -- such as false information about a person to try to have the person covered under the Plan as your **eligible dependent**; or
  - In communications with **Cigna** or the **plan administrator** (including a failure to contact the Your Cigna Life Service Center at 1.800.551.3539 or update your dependent information on the *Life Events* section of the *Your Cigna Life* website (*Self Service>Employee Self Service> Life Events* when there has been a change in dependent eligibility).
- You permit anyone who is not your **covered dependent** to use your or your **covered dependent's** Plan identification card or to obtain **covered services** and benefits.
- You submit a claim based on an intentional misrepresentation or make a fraudulent submission to the **claims administrator** or otherwise obtain or attempt to obtain **covered services** or benefits by means of false, misleading or fraudulent information, acts, or omissions.
- You fail to pay any **coinsurance**, supplemental charge or other amount due in connection with **covered services** and benefits.
- You threaten the life or well-being of Cigna Medical Plan personnel, individuals who provide services and benefits, or any Plan participant.

Termination of coverage under this provision due to an act, practice or omission by you that is fraudulent or due to your intentional misrepresentation of material fact may, in the **plan administrator's** sole discretion, cause coverage for you and your **covered dependents** to be cancelled retroactively to as early as when the coverage began. You will receive written notice describing the reasons for the termination of your coverage. Termination of coverage for reasons that constitute misconduct under **Cigna's** employment policies may also result in the termination of your employment.

Rescissions

Coverage under the Medical Plan may not be rescinded (retroactively terminated) by **Cigna** unless you (or someone seeking coverage on your behalf) (1) performs an act, practice or omission that constitutes fraud or (2) makes an intentional misrepresentation of material fact.

No Conversion Rights

The Medical Plan options are self-insured; that is, Plan benefits are not provided through any group health insurance policy. As a result, there are no conversion privileges when your Cigna Medical Plan coverage ends. You have no group health insurance coverage that can be converted to individual coverage when you are no longer a member of the group.

OVERVIEW OF MEDICAL COVERAGE AND HEALTH SAVINGS ACCOUNT

The Cigna Medical Plan combines medical coverage through a high deductible health plan (**HDHP**) with a special tax-advantaged savings account called a health savings account or HSA. This section first provides an overview of how your medical coverage works and then explains the features of your HSA, including:

- In-Network and Out-of-Network Services Overview;
- Overview of Claim Processing;
- Deductibles, Coinsurance and Out-Of-Pocket Maximum;
- Unlimited Lifetime Maximum Benefit;
- How to establish and contribute to your HSA; and
- How your HSA and medical coverage (i.e., your HSA option) fit together.

In-Network and Out-of-Network Services Overview

The Plan has a network of health professionals and facilities. You may receive care outside of the network, but the benefit levels are higher if you receive care from in-network health professionals and facilities:

- Certain services are covered only when you use in-network doctors. For more information, see the charts in Appendix I.
- The Plan pays the full cost of **preventive generic drugs** when you use Cigna Home Delivery Pharmacy.
- Your **deductibles**, **coinsurance** and **out-of-pocket maximum** are higher when you use out-of-of network services. See the charts in Appendix I.

The Plan uses Cigna's Open Access Plus with CareLink network, except as noted under "Special Network Plan Options" for limited network offerings in specific geographic areas. The directory of participating health care professionals, such as doctors, **hospitals** and **pharmacies**, is available online at *www.myCigna.com* under the tab, *Find a Doctor, Dentist, or Facility* or by calling the Customer Service Center at 1.888.99Cigna (1.888.992.4462).

You may use any health care professional in your network. No referrals from a **primary care physician** are required to get **specialist** care but preauthorization and other requirements may apply for certain services.

The Plan will not discriminate against a health care professional or facility that acts within the scope of its license or certification under applicable state law when choosing in-network health care professionals and facilities.

Overview of Claim Processing

When you receive in-network care, your health care professional or facility will send claims directly to the **claims administrator** for payment. When you receive care out-of-network, you may have to pay for the care and then file claims with the **claims administrator** for reimbursement.

You may not use HSA funds to pay for the medical expenses of your **partner** or a **dependent** child unless that person is considered your "tax dependent" under Section 152 of the Internal Revenue Code.

In either case, the **claims administrator** reviews the claim and sends an Explanation of Benefits (EOB) to you and your health care professional or facility. The EOB tells you what expenses are covered by the Plan, how much the Plan pays and what you owe. If you receive a bill from your health care professional, make sure the expense was sent to the **claims administrator** before you pay the bill. You can do this by checking on *www.myCigna.com*.

For prescription drugs, the pharmacist determines your out-of-pocket cost when the pharmacist fills your prescription.

Deductibles, Coinsurance and Out-Of-Pocket Maximum

Deductibles

A **deductible** is the annual dollar amount you are required to pay before the Medical Plan begins to pay its share of your **covered expenses**. After the **deductible** is met, you share in the cost of **covered expenses** at a percent called **coinsurance** as explained in this section below. The charts in Appendix I show the **deductibles** for each HSA option.

All **covered expenses** are subject to the annual **deductible**, except in-network preventive care, **preventive generic drugs** when you use Cigna Home Delivery Pharmacy, and other medications covered under the Patient Protection and Affordable Care Act.

Your **deductible** amount depends on your coverage tier- that is, whether you cover only yourself or also cover other family members. If you cover only yourself, you must meet the individual **deductible**. If you also cover family members, you have a higher collective **deductible**. With a collective **deductible** your out-of-pocket expenses for all **covered dependents** must reach the entire collective **deductible** amount before the Plan pays for covered expenses for you or your **covered dependents** at the **coinsurance** level.

Your **deductible** amount also depends on how you receive **covered services**. The **deductible** amount for in-network services is lower than the **deductible** amount for out-of-network services. Covered expenses will count toward both your in-network and out-of-network **deductibles** until you meet your in-network **deductible**. These expenses are combined to calculate the amount applied towards your annual in-network and out-of-network **deductibles**. However, once you reach your in-network **deductible** and pay a **coinsurance** percent for covered in-network services, those expenses are not subject to your in-network **deductible** and will not count towards your out-of-network **deductible**.

The following expenses do NOT count toward meeting your annual **deductible**:

- Expenses that are not subject to an annual **deductible**;
- Expenses that are not covered by the Medical Plan, including charges in excess of **maximum reimbursable charges**; and
- Any reduced benefits or penalties for failure to follow the "Prior Authorization," "Pre-Admission Certification/Continued Stay Review" and "Prior Authorization and Certification" procedures.
- Amounts you pay for the cost between the cost of the generic equivalent and the brand name drug when you fill the brand name drug and "dispense as written" is not indicated on the prescription.

Coinsurance

Once you have met your annual **deductible**, you pay part of the cost for **covered services** by paying **coinsurance**. **Coinsurance** is a percent of the **covered expense** that you must pay. The Plan pays the rest of the cost.

The charts in Appendix I show the **coinsurance** percentages for the Plan's **covered services** for each HRA option. For most **covered services**, the **coinsurance** percentages that you pay are higher for out-of-network services. See the charts in Appendix I.

Out-Of-Pocket Maximum

The Plan places an annual limit on what you must pay out-of-pocket toward your **deductible** and **coinsurance** share. That limit is the **out-of-pocket maximum**.

Once that limit is reached, the Plan pays 100% of the **maximum reimbursable charge** for most approved **covered services** and prescription drugs for the rest of the calendar year. The **out-of-pocket maximum** helps protect you from financial hardship if your medical expenses are unusually high during any single year.

Your **out-of-pocket maximum** amount depends on whether you have elected individual or family coverage and how you receive covered services. For individual coverage, you must meet the individual **out-of-pocket maximum** before the Plan pays expenses at 100%. For in-network family coverage, the Plan has a per-individual **out-of-pocket maximum** and

a family **out-of-pocket maximum**. Once an individual's **out-of-pocket maximum** is met, the Plan pays 100% of covered expenses for that individual, regardless of whether the family **out-of-pocket maximums** have been met. Once a family's **out-of-pocket maximum** is met, the Plan pays 100% of covered expenses for the family, regardless of whether the individual **out-of-pocket maximums** have been met.

For out-of-network family coverage, the entire family **out-of-pocket maximum** must be met before the Plan pays expenses at 100% for any family member. The in-network **out-of-pocket maximum** is lower than the out-of-network **out-of-pocket maximum**. Your out-of-pocket costs for in- and out-of-network **covered services** will count toward both your in-network **out-of-pocket maximum** and your out-of-network **out-of-pocket maximum** until you reach your in-network **out-of-pocket maximum**. In-network expenses which the Plan pays at 100% are not subject to your in-network **out-of-pocket maximum** and will not count towards your out-of-network **out-of-pocket maximum**.

The **coinsurance** and **deductible** amounts that you pay are applied toward meeting your **out-of-pocket maximum**. However, the following expenses do not count toward this maximum and they are not reimbursed at 100% once you reach the **out-of-pocket maximum**:

- Any penalties or reduced benefits for failure to follow the "Prior Authorization," "Pre-Admission Certification/Continued Stay Review" and "Prior Authorization and Certification" procedures.
- Expenses that are not **covered expenses**, including charges in excess of the **maximum reimbursable charge**.
- Expenses that are not subject to an annual **deductible.**
- Amounts you pay for the cost between the cost of the generic equivalent and the brand name drug when you fill the brand name drug and "dispense as written" is not indicated on the prescription.

Unlimited Lifetime Maximum Benefit

The Medical Plan has no lifetime maximum and will continue to pay for **covered services** as long as you and your family members are covered by the Plan.

Establishing a Health Savings Account

Special Requirements for Opening an Account

To be eligible for a health savings account, you must participate in an HSA option under the Cigna Medical Plan and meet certain requirements. If you are not eligible to make contributions to a health saving account, it does not impact your medical coverage and you can still continue to be enrolled in an HSA option.

You can open a health savings account as long as you are not claimed as a dependent on another person's tax return and are not enrolled in other health coverage that does not qualify as an **HDHP**, with certain exceptions described below. You are not eligible to open a health savings account if you are:

- Enrolled in Medicare;
- Enrolled in Medicaid;
- Receiving benefits under TRICARE; or
- Covered under any other health plan (including a Flexible Spending Account (FSA) or a stand-alone Health Reimbursement Account (HRA)) that is not a qualified **HDHP** unless it fits within one of the exceptions listed below.

You may make contributions to a health savings account if you have coverage under the following types of plan for:

- some disease-specific coverage (i.e., critical illness insurance);
- dental care;
- vision care;

- long-term care;
- disability;
- accident;
- "limited purpose" FSAs/HRAs, which can be used only for dental or vision expenses; or
- "post-deductible" FSAs/HRAs, which provide coverage only after you satisfy the deductible under an **HDHP.**

For employees who enroll in an HSA option, the Cigna Health Care Flexible Spending Account provides limited purpose and post-deductible coverage that meets these exception rules, which will allow you to make contributions to a health savings account. See the Cigna Health Care Flexible Spending Account Summary Plan Description on the *Your Cigna Life* website (click on *Self Service>Forms, Tools & Resources*) for more information about that plan.

Your HSA account will be active as of the first day of the month following your eligibility and enrollment in the HSA option of the Medical Plan. You will not be eligible to make HSA contributions for any month in which you are traveling on **Cigna** business outside the U.S. and are covered under another **Cigna**-sponsored plan that provides medical benefits for **Cigna** employees traveling abroad on business. Your overall contributions for the year must be adjusted pro rata for any months in which you have this other coverage.

Other restrictions may apply. Internal Revenue Service Publication 969 provides information about the requirements for a plan to qualify as an **HDHP** and the requirements you must meet to qualify for an HSA. You may contact the Cigna Customer Service Center at 1.888.99Cigna (1.888.992.4462) for assistance.

During the **plan year**, you may be required to confirm your eligibility to continue to make contributions to your account (example: if you become Medicare-eligible because of your age, you may be asked to demonstrate that you have not enrolled in Medicare).

Federal HSA Contribution Limits

By law, the maximum annual contribution that can be made to your account, including both **Cigna's** contributions and your contributions (pretax and after-tax) is:

- For 2018, $3,450 for individual coverage; or
- For 2018, $6,900 for family coverage.

These amounts are indexed annually by the federal government and are subject to change each year. The annual maximum contribution is the total contribution from all sources (payroll contributions by you and/or **Cigna** and personal contributions you deposit directly) to all accounts.

If married employees are both eligible to contribute to separate HSAs, the contribution limit for 2018 for both accounts combined is based on the maximum amount that can be contributed for a family - $6,900. Note, however, if either person is age 55 or older in 2018, the total combined contribution is increased by $1,000 for each individual age 55 or older. (See below).

It is important to monitor contributions to your HSA—there will be adverse tax consequences if your contributions exceed the annual limit that has been set by the Federal government. Changes in coverage during the year, continuous enrollment in an HSA option for less than 12 months or enrollment after the beginning of the year can all affect your contribution limits. If you become aware during the year that combined contributions to your HSA exceed the annual limit, you can withdraw the excess amount and the related interest earnings before your income tax return for the year is due (including extensions).

For assistance and information about the contribution limits, call the Cigna Customer Service Center at 1.888.99Cigna (1.888.992.4462).

If You Are Age 55 or Older

If you are age 55 and older, you can make additional contributions to your HSA. These are called catch-up contributions and can be made by payroll deductions just like your normal contribution. The catch-up contribution limit is $1,000.

If you also cover your **spouse/partner** under the HSA option and your **spouse/partner** is age 55 or older, he or she may also be eligible to open a second HSA and contribute catch-up contributions. **Cigna** will not contribute funds or pay any fees associated with the HSA for your **spouse/partner**.

Please call the Cigna Customer Service Center at 1.888.99Cigna (1.888.992.4462) for information about catch up contributions and how to open a second HSA for your **spouse/partner**.

Setting Up a Health Savings Account

The **custodian** of the HSA fund, will automatically open an HSA for you when you enroll in an HSA option, as long as you provide identification in accordance with the USA Patriot Act. The contact for the **custodian** is: Cigna Customer Service Center at 1.888.99Cigna (1.888.992.4462) or use the myCigna.com email box. If the **custodian** does not automatically open an HSA for you, you should call the Cigna Customer Service Center.

Contributing to Your Health Savings Account

Once you have opened a health saving account, you can decide whether to make contributions to it. Your contributions are tax-free up to federal limits and any dollars in your health savings account earn interest on a tax-free basis.

The balance in your HSA rolls over from year to year, increasing your savings for future medical expenses. You own the balance in your account, and can save it, invest it in funds offered through the **custodian** or spend it on qualified medical expenses. If you change employers or retire, the balance in your account belongs to you as the account holder.

Your Contributions

You can make pre-tax contributions through payroll deductions each pay period up to the legal limit (taking into account **Cigna's** contributions), provided your account remains open and you are enrolled in an HSA option. Payroll contributions can only be made to HSAs through the Cigna Medical Plan arrangement with the **custodian.**

When you enroll in the HSA option, you will be asked how much you want to contribute to your account during the **plan year**. This amount will automatically be divided by the number of pay periods that you expect to receive a paycheck. You may change the amount of your deduction at any time by contacting the Your Cigna Life Service Center (1.800.551.3539 or YourCignaLifeServiceCenter@Cigna.com). The change will start with the next available pay check following the processing of your request.

You may also make additional personal contributions to your account by electronic funds transfer or by mailing a check, along with a deposit coupon available on *myCigna.com>Manage Claims & Balances.* The contributions will be made on an after-tax basis. Check with your tax advisor to determine if you can deduct them from your federal or state tax return. Contributions for the current **plan year** can be made until the IRS deadline for filing income tax returns (April 15).

If you enroll in Medicare, you are prohibited from contributing to your account beginning with the first month you are enrolled. Note that enrollment in Medicare may be a **life status change** event that would permit you to make a change in your Cigna Medical Plan coverage outside of the annual enrollment period. See the "If You Have a Life Status Change" section of this SPD for further details.

Cigna's Contributions

As long as your account remains open and you are enrolled in an HSA option, **Cigna** may also make contributions to your account. **Cigna's** contribution is a fixed amount each pay period and the amount that **Cigna** contributes each **plan year** depends on:

- The coverage tier (employee only or employee plus other family members) that you elect;
- When during the year your coverage starts; and

- Whether you satisfy any additional requirements that must be met to receive the maximum HSA contribution. You will receive information about any such requirements during the annual benefits enrollment period (or when you enroll if you become eligible to enroll mid-year).

The chart in Appendix I provides details on **Cigna's** HSA contribution amounts and any requirements that apply to receive the maximum HSA contribution from **Cigna.**

When Contributions Are Made

Biweekly contributions will be made to your HSA, once you have set up your account and **Cigna** is notified that it is open. The amount of your biweekly contribution will be based on the goal amount you set when you enrolled, divided by the number of available pay periods.

Cigna's contribution is incremental and retroactive to the day that your coverage started for the **plan year**. **Cigna's** contribution can only be made to HSAs through the Cigna Medical Plan arrangement with the **custodian** and **Cigna's** contribution will end when your employment ends or your coverage under the HSA option is cancelled, whichever comes first.

To receive employer contributions for the **plan year**, you must establish your account by December 31st of the **plan year**. If you do not establish an HSA with the **custodian** by December 31st of the **plan year**, no employer contributions will be made for that **plan year**.

If you are on an unpaid leave, including FMLA or while receiving Long-Term Disability benefits, employer contributions will continue to be credited to your account. However, you will not have access to these employer contributions made during your unpaid leave until you return to work or at the end of the **plan year**, whichever comes first.

If you experience a **life status change** event, please contact HSA Member Services Center at 1.866.524.2483 to discuss how this may impact your account. In the event that the **life status change** event results in contributions in your account above the annual maximum contribution allowed under IRS guidelines, you can withdraw the excess contributions by your tax filing deadline to avoid additional taxes.

Funds will no longer be contributed once **Cigna** receives notification that your account has been closed.

Managing Your Health Savings Account

Paying Qualified Medical Expenses from Your Health Savings Account

With a health savings account, you can pay for qualified medical expenses with tax-free dollars.

The IRS has compiled a list of qualified expenses that may be reimbursed by your HSA tax-free. A qualified expense is identified in Code section 213(d). These are explained in IRS Publication 502 and generally include medical, dental and vision expenses, chiropractic care and acupuncture. Note that amounts paid for over-the-counter drugs are considered qualified expenses only if the drugs are prescribed by a doctor. In addition, amounts you pay toward the cost of health coverage are generally not considered qualified expenses (with limited exceptions) unless you are age 65 or over. If you have questions about qualified medical expenses, please contact HSA Member Services at 1.866.524.2483.

Once you have funds in your account, you may pay your out-of-pocket medical expenses incurred on or after the date your HSA was opened. You may use your HSA debit card, online bill payment, self-reimbursement/direct deposit or check to withdraw money from your account. You also may choose to cover your expenses using your own funds and allow your HSA to grow. See *myCigna.com>Manage Claims and Balances* for more information and any fees that may apply to you.

You may also authorize the **claims administrator** to automatically forward medical expenses, for which you are responsible (example: **deductible** and **coinsurance**) to your HSA for payment once your claim is processed. This is called Automatic Claim Forwarding (ACF), which you can elect by completing an automatic claim forwarding authorization form available on *myCigna.com.*

If you use your account dollars for expenses that are not qualified medical expenses, you will be subject to federal income tax, as well as a 20 percent penalty if you are under age 65. You will be required to report the distribution and any applicable penalty on your federal and possibly your state tax return.

Earning Interest on Your HSA

The balance in your account earns interest, which is tax-free. For interest rate information on your account, visit *myCigna.com>Manage Claims and Balances* for the Health Savings Account or call HSA Member Services at 1.866.524.2483.

Investing Your HSA

The **custodian** offers investment options within your HSA. HSA investment accounts provide the option of investing in mutual funds as part of a longer-term savings program. The initial investment must be at least $2,000 and any money transferred to an investment account is not available for direct payment of eligible medical expenses. Investments are not guaranteed or FDIC insured. Contact the HSA Member Services at 1.866.524.2483 for more information.

HSA Fees

Cigna will pay the **custodian's** account set-up fee if you are newly enrolled in an HSA option and do not have an existing HSA. **Cigna** will also pay the monthly maintenance fees while you are enrolled in an HSA option. **Cigna** will not pay overdraft fees, excess contribution fees, lost card or replacement check fees. If you are enrolled in COBRA, terminate employment with **Cigna,** otherwise become ineligible for coverage under the Cigna Medical Plan, or are no longer enrolled in the HSA option, all associated fees will become your responsibility. These fees will be deducted automatically from your HSA balance, if any of these events occur.

Visit *myCigna.com>Manage Claims and Balances* for the Health Savings Account or contact HSA Member Services at 1.866.524.2483 to learn about the fees for various HSA services. It is your responsibility to check your account balance prior to using funds to pay for services.

If You Leave Cigna or Are No Longer Enrolled in the HSA Option

The balance in your health savings account belongs to you as the account holder, even if you enroll in COBRA (or choose not to enroll in COBRA), change options (are no longer enrolled in the HSA option), end your medical coverage, change jobs or leave **Cigna**. In these events, all fees associated with the account will become your responsibility.

Closing Your Account

The balance in your account belongs to you and you may use these funds to pay for qualified medical expenses on a tax-free basis. If you choose to no longer maintain the account, it is your responsibility to close your account (for example, if you are no longer enrolled in an HSA option and do not wish to maintain your account).

Tax Considerations

With a health savings account you have the ability to contribute to your account on a tax favored basis. Interest earnings or earnings on investments made through your HSA will not be taxed as long as the funds remain in your account.

In addition, all HSA withdrawals for qualified medical expenses are tax-free. If funds are used for expenses that are not qualified medical expenses, income tax will apply and a 20 percent penalty may also apply.

Filing Your Income Tax Return

Each January you will receive tax forms to report distributions, contributions and the market value of your HSA for the previous calendar year. You should save all of your medical expense receipts for income tax purposes.

Form 1099-SA reports the distributions from your HSA in the previous calendar year. In May, you will receive Form 5498-SA which reports the contributions to your HSA either "in" or "for" the previous calendar year and the fair market value of your account as of December 31.

Under IRS guidelines, you must file a Form 8889 with your federal tax return if you (or someone on your behalf, including **Cigna**) make contributions to an HSA during the year. Form 8889 must also be filed if you have an HSA balance or use HSA funds during the year, even if you do not make contributions to your account in that year.

Note: State tax law may differ from federal tax law in certain states, including:

- Alabama
- California
- New Jersey

Please consult your tax advisor or HSA Member Services at 1.866.524.2483 if you have questions about the tax forms mentioned above.

COVERED EXPENSES

This section describes the services and supplies covered under the HSA options. All HSA options cover the same services and supplies. References in this section to the "Plan" are to these options. Claim determinations are based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary and/or appropriate for you is between you and your **physician**. However, just because you or your **physician** decides a service is necessary or appropriate does not mean the service will be paid for by the Plan.

General Requirements for Covered Expenses

To be **covered expenses**, services or supplies must be recommended by a **physician** and **medically necessary** for the care and treatment of an injury or sickness as determined by **Cigna HealthCare** or for covered preventive care services.

Preauthorization or Certification

Certain services are covered under the Plan only if you meet preauthorization or certification requirements. For example, preauthorization or certification requirements apply to:

- Non-emergency ambulance use;
- Infertility treatment;
- Home health care and home infusion therapy;
- Transplant services;
- External prosthetic appliances and devices;
- Durable medical equipment;
- Gender reassignment surgery;
- Genetic Testing;
- Prescriptions that require prior authorization as noted on the **drug list** at *www.myCigna.com*;
- Injectable drugs;
- **Hospital** admissions;
- Outpatient surgical procedures;
- Diagnostic cardiology;
- Diagnostic testing using advance radiological imaging (CT Scans, MRI, MRA or PET scans);
- Dialysis;

- Radiation therapy; and
- Speech therapy.

Maximum Reimbursable Charges

When you receive care in-network, your cost will generally be lower because charges are subject to discounts negotiated by **Cigna HealthCare** and the Plan generally pays a greater share of the cost than if you receive care out-of-network. Charges for out-of-network services are covered only up to the **maximum reimbursable charge**. This is the maximum amount the Plan pays for out-of-network care. You are responsible for any amount above this maximum limit.

The **maximum reimbursable charge** for **covered services** is determined based on the lesser of:

- The health care professional's normal charge for a similar service or supply; or
- 110% of the schedule developed by the **claims administrator** that is based on a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

In some cases, a Medicare based schedule will not be used and the **maximum reimbursable charge** for **covered services** is determined based on the lesser of:

- The health professional's normal charge for a similar service or supply; or
- The 80th percentile of charges for such service or supply by other health care professionals in the geographic area where it is received as compiled in a database selected by the **claims administrator**.

The **maximum reimbursable charge** is subject to all other benefit limitations and Plan provisions, and applicable coding and payment methodologies determined by the **claims administrator**. Additional information about how the **claims administrator** determines the **maximum reimbursable charge** is available upon request. To obtain the **maximum reimbursable charge** for a particular procedure or treatment, contact the Customer Service Center at 1.888.992.4462.

Calculation of Covered Expenses

The **claims administrator** will calculate **covered expenses** after evaluating and validating the bills submitted for payment in accordance with the most recent edition of the Current Procedural Terminology (CPT) codes published by the American Medical Association and generally recognized methodologies for claims administration.

PHYSICIAN, HOSPITAL AND RELATED SERVICES

Preventive Care

The Plan covers preventive care, which includes health screenings and interventions, and immunizations. Preventive exams are comprehensive in relation to age and gender and consist of an appropriate history and exam, anticipatory guidance, education regarding risk reduction interventions and a psychosocial/behavioral assessment. The Plan pays the full cost of preventive care services if you receive them in-network. Your network doctor determines how often preventive care services are needed based on such factors as your age and medical history.

For certain services, you must use in-network health care professionals for these services to be covered by the Plan. If they are received out-of-network, you will be responsible for the cost of these services. See the charts in Appendix I for more information on how your share of the cost for out-of-network preventive care is determined.

The Plan also pays the full cost of the following preventive care services if you receive them in-network. Detailed information is available at https://www.healthcare.gov/what-are-my-preventive-care-benefits/:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the person involved;

- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- For women, such additional preventive care and screenings not described in the first item above as provided for in comprehensive guidelines supported by the Health and Resources Services Administration.

A list of commonly recognized preventive care services is also available on the *Your Cigna Life* website (*Health & Well-Being>Medical).*

Inpatient Hospital Services

The Plan covers inpatient **hospital** services, as described in this section and in the charts in Appendix I if you are a registered bed patient in a **hospital** on the recommendation of a **physician**.

The Plan covers charges made by a **hospital**, on its own behalf, for **bed and board** and other necessary services and supplies. **Covered expenses** for **bed and board** and **hospital** services include:

- Semi-private room and board unless **Cigna HealthCare** determines a private room is **medically necessary**;
- Care and services in an intensive care unit;
- Administered drugs, medications, biologicals and fluids;
- Special diets;
- Dressings and casts;
- General nursing, unless **Cigna HealthCare** determines private duty nursing is **medically necessary**;
- Use of operating room and related facilities;
- The administration of blood and blood products;
- X-ray, laboratory and other diagnostic services;
- Anesthesia and oxygen services;
- Inhalation therapy;
- Radiation and chemotherapy;
- Physical, speech and occupational therapy; and
- Other services customarily provided in acute care **hospitals**.

Cigna HealthCare must authorize any non-emergency **hospital** admission in advance. If you receive in-network care, a network health professional will obtain that authorization for your admission to a network **hospital**. For more information about certifying a **hospital** stay, see the "HOSPITAL PRE-ADMISSION CERTIFICATION AND CONTINUED STAY REVIEW REQUIREMENTS" chart.

Outpatient Hospital Services

The Plan covers charges made by a **hospital**, on its own behalf, for medical care and treatment received as an outpatient.

Diagnostic Outpatient Testing

The Plan covers charges for diagnostic, x-ray and laboratory tests performed on an outpatient basis if the services are recommended by a **physician**, and are **medically necessary** for the care and treatment of an illness or injury.

Radiation and Chemotherapy

The Plan covers charges for radiation and chemotherapy treatments performed on an outpatient basis.

Outpatient Surgery

The Plan covers charges by a **hospital**, **free-standing surgical facility** or other approved surgical facility for medical care for outpatient surgery. **Medically necessary** services and supplies offered in conjunction with the surgery are also covered, including:

- Lab tests and x-rays;
- Drugs and medications;
- Biologicals and fluids;
- Anesthesia and its administration;
- Administration of blood and blood products; and
- Recovery room services.

Physician, Surgeon and Associated Medical Services

The Plan covers charges for the diagnosis, treatment and care for an illness and injury whether you receive the services in an office, **hospital** or at home. Your coverage includes the necessary diagnostic tests and x-rays, injections, casts and dressings, and **physician** services in the **hospital** as well as surgical services provided by a surgeon, assistant surgeon, co-surgeon and anesthesiologist.

When a surgeon performs two or more surgical procedures during the same operation, the maximum amount the Plan will pay is the amount that would be payable for the most expensive procedure, plus one-half of the amount that would be payable for all other procedures.

If an assistant surgeon is **medically necessary**, the maximum amount the Plan will pay for the assistant surgeon's charges is limited to 20% of the surgeon's allowable charge (before any reductions due to **coinsurance** or **deductible** amounts).

The maximum amount the Plan will pay for charges made by co-surgeons is limited to 20% of the surgeon's allowable charge (before any reductions due to **coinsurance** or **deductible** amounts) plus 20%.

The Plan requires treatment decision support coaching for elective hip, back, and knee surgery. If you do not complete all steps of the coaching at least 30 calendar days before your scheduled surgery, your covered benefit will be reduced by $1,000. If you undergo one of these procedures due to an emergency, the penalty will not apply. For more information or to complete the pre-surgical decision support program, call the Customer Service Center at 1.888.99Cigna (1.888.992.4462).

Anesthesia/X-Ray & Laboratory Services

The Plan covers charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.

The Plan also covers charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.

Ambulance Service

The Plan covers charges by a licensed ambulance service for transportation to or from the nearest **hospital** where the needed emergency medical care and treatment can be provided. Non-emergency ambulance use must be authorized in advance by **Cigna HealthCare**.

Maternity Care

The Plan covers maternity care for you and your **covered dependents**. "Maternity care" includes medical and surgical services and care at a **hospital** or free-standing birthing center during the term of pregnancy, upon delivery, and during the

postpartum period. Normally, **physicians** bill one all-inclusive fee for the delivery and all related exams. This fee is considered a surgical charge and is subject to the applicable **coinsurance**. Plan coverage includes:

- Pre- and post-delivery exams;
- Normal deliveries;
- Spontaneous abortion (miscarriage);
- Cesarean section;
- Elective termination of pregnancy (abortion); and
- Complications due to pregnancy.

For your **coinsurance** and **deductible** amounts, see the charts in Appendix I.

Newborn Care

Coverage for maternity care includes services for the newborn. **Cigna HealthCare** will create a separate claim file for your new baby.

Plan coverage for your newborn child is automatic for the first 30 days from the date of birth. To have coverage for your new child after the first 30 days, you must enroll the child as a **covered dependent** in the Plan. See "Enrolling Newborn Children" for instructions on how to enroll your newborn.

Note: Automatic Plan coverage for the first 30 days does not apply to a child born to your female **covered dependent** child. A child born to your female dependent child is NOT covered under the Cigna Medical Plan for other than routine **hospital** nursery care, unless the newborn qualifies as your **eligible dependent** and you enroll this infant in the Plan.

Therapies for Participants Diagnosed with Autism Spectrum Disorder

The Plan's covered services include a maximum of 60 days per **plan year** of physical therapy, occupational therapy, and speech therapy for participants who have been diagnosed with autism spectrum disorder (not to be combined with the Plan's standard rehabilitation services).

The Plan's covered services also include unlimited treatment days for Applied Behavior Analysis therapy for autism spectrum disorders as described in the charts in Appendix I.

Voluntary Family Planning

The Plan's **covered services** include:

- 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; and
- Charges made for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.

Infertility Services

The Plan covers in-network charges made for services related to the diagnosis of infertility and the 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;
- The inability of a woman to achieve conception after six trials of artificial insemination over a one-year period; or
- The inability of opposite-sex partners to achieve conception after six months of unprotected intercourse for a woman over the age of 35.

This benefit includes diagnosis and treatment of both male and female infertility. However, the Plan does not cover any of the following 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;
- Attempts at artificial insemination, with or without superovulation drug therapy, more than 12 months after the start of such treatment;
- Surrogate mothers; and
- Any experimental, investigational or unproven infertility procedures or therapies.

The Plan does not cover out-of-network charges for infertility services.

Special Preauthorization Requirements

Before starting a program for treatment of infertility, your network doctor must submit the proposed treatment plan to **Cigna HealthCare** for review and initiate the case management process. **Cigna HealthCare** reviews your medical history and notifies your network doctor of the services authorized for Plan coverage. Also, participants must enlist the services of a Healthy Life Personal Health Team coach to receive infertility benefits from the Plan.

Lifetime Maximum Benefit for Infertility Diagnosis and Treatment

The Plan covers up to $10,000 of the cost of all **covered services** related to the diagnosis and treatment of infertility for you over your lifetime, or $15,000 when a **Center of Excellence** is used.

Skilled Nursing and Other Health Care Facility

The Plan covers charges made by **other health care facilities** (including a **skilled nursing facility**, a rehabilitation **hospital** or a subacute facility) for medical care and treatment.

The Plan will cover a maximum number of days per calendar year, as described in the charts in Appendix I, in a licensed **skilled nursing facility**. This treatment maximum applies to the total of services you receive from both in-network and out-of-network health professionals. Coverage will be based on whether **Cigna HealthCare** determines that treatment in a **skilled nursing facility** is **medically necessary** and appropriate. **Covered services** include:

- Semi-private room and board;

- Skilled and general nursing services;
- Physician visits;
- Physiotherapy;
- X-ray; and
- Administration of drugs, medications, biologicals and fluids.

In the case of a **skilled nursing facility**, you must be admitted to the facility within 10 days after the end of your **hospital** confinement for the same illness or injury. The Plan covers the extended-care treatment only if your preceding **hospital** confinement was also covered. If **Cigna Healthcare** determines that treatment in a **skilled nursing facility** is an acceptable alternative to a **hospital** stay, it will waive these requirements.

Two or more successive stays in an extended-care facility for the same or a related illness or injury will be considered one stay unless the periods are separated by a period of at least 14 days during which there is also no **hospital** stay.

Home Health Services

The Plan covers charges made for home health services when you:

- Need skilled care;
- Cannot obtain the required care as an ambulatory outpatient; and
- Do not require a stay in a **hospital** or **other health care facility**.

Home health services are provided only if **Cigna HealthCare** has determined in advance that the home is a medically appropriate setting. In the case of a minor or an adult who is dependent on others for non-skilled care and/or **custodial services** (e.g., bathing, eating, toileting), home health services will be provided only when another family member or caregiver is present in the home to meet any needs for non-skilled care and/or **custodial services**.

Home health services are services that can be provided during home visits by **other health care professionals**. The services of a home health aide are covered when these services are in direct support of skilled health care services provided by **other health care professionals**. A visit is defined as a period of 2 hours or less. The Plan covers up to a maximum of 16 hours of home health services per day. Necessary consumable medical supplies and home infusion therapy administered or used by **other health care professionals** in providing home health services are covered.

Home health services do not include services by a person who is a member of your family or your **covered dependent's** family or who normally resides in your house or your **covered dependent's** house even if that person is an **other health care professional**.

Skilled nursing services or private duty nursing services provided in the home are subject to the rules that apply to home health services. Physical, occupational, and other short-term rehabilitative therapy services provided in the home are subject to the rules that apply to short-term rehabilitative therapy in the charts in Appendix I; they are not considered home health services.

Hospice Care Services

Covered expenses include 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; and
  - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a **physician**; and laboratory services; but only to the extent those charges would have been payable under the policy if the person had remained or been confined in a **hospital** or **hospice facility**.

The Plan does NOT cover the following **hospice care services**:

- Services by a person who is a member of your family or your **covered dependent's** family or who normally resides in your house or your **covered dependent's** house;
- Services for any period when a person is not under the care of a **physician**;
- Services or supplies not listed in the **hospice care program**;
- Any curative or life-prolonging procedures;
- Expenses for services and supplies to the extent that any other benefits are payable for those expenses under the Plan; and
- Services or supplies that are primarily to aid in daily living.

Short-Term Rehabilitative Therapy and Chiropractic Services

The Plan covers the following charges made for short-term rehabilitative therapy and chiropractic services as shown in the charts in Appendix I. There is a limit on what the Plan will cover. This limit applies to the total of services you receive from both in-network and out-of-network health professionals.

- Charges made for short-term rehabilitative therapy that is part of a rehabilitative program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.
- Charges for diagnostic and treatment services that are provided by a chiropractic **physician** when provided in an outpatient setting. Services of a chiropractic **physician** include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

The following limitations apply to short-term rehabilitative therapy and chiropractic care services:

- To be covered, all therapy services must be restorative in nature. Restorative therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of injury or sickness. Restorative therapy services do not include therapy designed to acquire levels of function that had not been achieved before the injury or sickness.
- Services are not covered if they are custodial, training, educational or developmental in nature.
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an injury or sickness.

The Plan does NOT cover:

- 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; or
- Maintenance or preventive treatment consisting of routine, long term or non-**medically necessary** care provided to prevent recurrences or to maintain the patient's current status.

The Plan does not cover these chiropractic care services:

- Services of a chiropractor that are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting; or
- Vitamin therapy.

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

Acupuncture Services

The Plan covers acupuncture as medically necessary for any of the following indications:

- Nausea and vomiting associated with pregnancy;
- Nausea and vomiting associated with chemotherapy;
- Postoperative nausea and vomiting; and
- Postoperative dental pain.

Acupuncture is covered as an adjunct to standard conservative therapy for the treatment of the following chronic, painful conditions when other conservative methods of treatment have failed, there is limitation resulting in impaired activities of daily living, and there is reasonable expectation acupuncture treatment will result in significant therapeutic improvement over a clearly defined period of time:

- Migraine or tension headache;
- Osteoarthritic knee pain;
- Neck pain; and
- Low back pain.

The Plan does not cover acupuncture when treatment is unlikely to result in sustained improvement or when there is no defined endpoint, including preventive, maintenance or supportive care, because it is considered not **medically necessary**.

Acupuncture also is not covered for any other indication, because it is considered experimental, investigational or unproven.

Acupuncture point injections are not covered for any indication because they are considered experimental, investigational or unproven.

Internal Prosthetic Appliances

The Plan covers internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functional body parts. The Plan also covers the **medically necessary** repair, maintenance or replacement of covered internal prosthetic appliances.

Breast Reconstruction and Breast Prostheses

The Plan covers charges made for reconstructive surgery following a mastectomy. Benefits include:

- Surgical services for reconstruction of the breast on which surgery was performed;
- Surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
- Postoperative breast prostheses; and
- Mastectomy bras and 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

The Plan covers 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 temporomandibular joint (TMJ)) disorder provided that:

- The surgery or therapy restores or improves function;
- Reconstruction is required as a result of **medically necessary**, non-cosmetic surgery; or
- The surgery or therapy is performed before 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 under the procedures described in the "If You Need to Be Hospitalized - Authorization/Certification Requirement" section.

Transplant Services

The Plan covers 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. All transplant services must be authorized in advance by **Cigna HealthCare**.

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, except cornea, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities. Transplant

services, including cornea, received at participating facilities specifically contracted with **Cigna** for those transplant services, other than Cigna LIFESOURCE Transplant Network® facilities, are payable at the in-network level. Transplant services received at any other facilities, including non-participating facilities and participating facilities not specifically contracted with **Cigna** for transplant services, are payable 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 consists of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken before 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 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 and lodging are available to the recipient of a preapproved organ/tissue transplant from a designated Cigna LifeSOURCE Transplant Network® facility. A recipient is a person receiving authorized transplant related services during any of the following stages:

- Evaluation,
- Candidacy,
- Transplant event, or
- Post-transplant care.

Travel expenses for the person receiving the transplant 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). These travel expense charges will also be covered for one companion accompanying a recipient. A companion includes a recipient's **spouse**, **partner,** a member of the recipient's family, the recipient's legal guardian, or any person not related to the recipient, but actively involved as the recipient's caregiver. Lodging expenses while at, or traveling to and from the transplant site will be covered up to a maximum of $50 per day for one person and $100 per day for two people. Lodging expenses in excess of the daily limits will not be covered.

The following travel expenses are NOT covered:

- Costs for travel within 60 miles of your home,
- Food and meals,
- Laundry bills,
- Telephone bills,
- Alcohol or tobacco products, and
- Charges for transportation that exceed coach class rates.

These transplant benefits are only available when you or your **covered dependent** is the recipient of an organ transplant. The Plan does not provide any benefits for a transplant donor.

External Prosthetic Appliances and Devices

The Plan covers charges made or ordered by a **physician** for the initial purchase and fitting of external prosthetic appliances and devices that are: (1) available only by prescription, and (2) necessary for the alleviation or correction of injury, sickness or congenital defect. Coverage is limited to the most appropriate and cost-effective alternative as determined by **Cigna HealthCare**.

External prosthetic appliances and devices include:

- Prostheses/prosthetic appliances and devices (replacements for missing body parts);
- Orthoses and orthotic devices (orthopedic appliances or apparatuses used to support, align, prevent or correct deformities);
- Braces (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); and
- Splints (an appliance for preventing movement of a joint or for the fixation of displaced or movable parts).

Prostheses/Prosthetic Appliances and Devices

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

The Plan covers only the following custom foot orthoses:

- For those 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 those with neurologic or neuromuscular conditions (e.g., cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The Plan covers the following other orthoses:

- 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.

The Plan does NOT cover the following 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 is 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;
- Orthoses primarily for improved athletic performance or sports participation; and
- External and internal power controls of prosthetic limbs and terminal devices, and myoelectric prostheses-peripheral nerve stimulators.

Braces

The Plan does not cover Copes scoliosis braces.

The Plan covers replacement of external prosthetic appliances and devices as follows:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse is not covered.
- Replacement 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 to:
  - No more than once every 24 months for those 19 years of age and older; and
  - No more than once every 12 months for those 18 years of age and under unless replacement is due to a surgical alteration or revision of the site.

External Prosthetic Appliances-Wigs

The Plan covers charges for wigs, sometimes referred to as hair prostheses or cranial hair prostheses, if hair loss is due to chemotherapy and/or radiation treatments for cancer, alopecia aerata, metabolic diseases, or injury. To be covered, the wig must be ordered by a **physician**. Covered charges are subject to the **deductible** and to the same **coinsurance** level as for other external prosthetic devices and appliances, and are limited to an annual maximum of $500.

Hearing Aids

The Plan covers charges for hearing aid devices used to amplify sound. Covered charges for hearing aids are subject to the **deductible** and to the same **coinsurance** level as for external prosthetic devices and appliances, and are limited to a per device maximum of $1,500. Covered charges under the Plan are limited to 2 hearing aid devices every 36 months. Coverage under the Plan includes charges associated with the testing and fitting of a hearing aid device.

Durable Medical Equipment

The Plan covers the purchase or rental of certain durable medical equipment listed in this section. To be covered, the equipment must be (1) ordered or prescribed by a **physician** and (2) provided by a vendor approved by the **claims administrator** for use outside a **hospital** or **other health care facility**.

The Plan covers repair, replacement or duplicate equipment only when required due to anatomical change and/or reasonable wear and tear. The Plan does not cover maintenance and repairs that result from your misuse. Coverage for durable medical equipment is limited to the lowest-cost alternative as determined by **Cigna Healthcare**. 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.

Durable medical equipment includes, but is not limited to, crutches, **hospital** beds, respirators, wheel chairs, and dialysis machines. Durable medical equipment that is not covered includes:

- Bed-related items, including bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses;
- Bath-related items, including 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, including 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, including ceiling lifts and wheelchair ramps;
- Car/van modifications;
- Air quality items, including room humidifiers, vaporizers, air purifiers and electrostatic machines;
- Blood/injection related items, including blood pressure cuffs, centrifuges, nova pens and needleless injectors;
- Other equipment, including 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.

Smoking Cessation Programs

The Plan covers smoking cessation programs that are offered by local **hospitals**, clinics and nonprofit organizations and that combine education, behavior modification and group support.

Eye Care

The Plan covers expenses related to the care of eye injuries and conditions that affect the health of the eye such as cataracts, glaucoma and complications from diabetes and high blood pressure. The Plan does not cover routine vision exams.

Dental Expenses

The Plan does NOT cover most dental expenses. The Cigna Dental Plan, which is described in the Cigna Dental Plan SPD, may cover your dental expenses. However, the Cigna Medical Plan does cover the following dental expenses, if your **physician** authorizes the services:

- Charges resulting from dental work needed because of an accidental injury to sound natural teeth, if you have the accident while covered under the Cigna Medical Plan; and
- Charges incurred at a **hospital** or **free-standing surgical facility** in connection with dental surgery.

A **hospital** stay related to dental treatment is covered only if it is certified as **medically necessary** and authorized by **Cigna HealthCare**.

Temporomandibular Disorders

The Plan covers treatment for problems with the temporomandibular joint (TMJ) and associated muscles for chewing if authorized by **Cigna HealthCare** as being **medically necessary**. **Covered services** include, but are not limited to splints, physical therapy, trigger point injections and surgical procedures.

The Plan does NOT cover:

- TMJ treatment involving the teeth, such as crowns, inlays/onlays, bridges, full and partial dentures or orthodontics; or
- Treatment for mandibular or maxillary prognathism, miscoprognathism or malocclusion, surgical/augmentation for orthodontics or maxillary construction.

Orthognathic Surgery

The Plan covers orthognathic surgery (corrective jaw surgery) to repair or correct severe facial deformity or disfigurement that orthodontics alone cannot correct if:

- 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 before age 19 and is needed because of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when (1) the previous orthognathic surgery met the above requirements, and (2) there is a high probability of significant additional improvement as determined by **Cigna HealthCare**.

Gender Reassignment Surgery

The Plan covers gender reassignment surgery as medically necessary when the individual is age 18 or older, has confirmed gender dysphoria and is an active participant in a recognized gender identity program. Covered expenses include charges for medical and/or psychological counseling and hormone therapy in preparation for, or subsequent to, any such surgery.

The Plan does not cover cosmetic surgery, even when it is performed as a component of a gender reassignment. The Plan also does not cover services related to the preservation of fertility or reproductive tissue.

Special Preauthorization Requirements

All services must be authorized in advance by **Cigna HealthCare**. The attending **physician** must submit a proposed treatment plan to **Cigna HealthCare** for review and to initiate the case management process. **Cigna HealthCare** will review the individual's medical history and notify the attending **physician** of the services authorized for Plan coverage.

Clinical Trials

The Plan covers routine patient care costs/services related to a clinical trial for a qualified individual consistent with the Patient Protection and Affordable Care Act (PPACA) requirements. The individual must be eligible to participate according to the trial protocol and EITHER of the following conditions must be met:

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

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

- Federally funded trial: The study of investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - National Institutes of Health (NIH)
    - Centers for Disease Control and Prevention (CDC)
    - Agency for Health Care Research and Quality (AHRQ)
    - Centers for Medicare and Medicaid Services (CMS)
    - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA)
    - A qualified non-governmental research entity identified in NIH guidelines for center support grants
    - ANY of the following:
        - Department of Defense

- Department of Veterans Affairs
- Department of Energy

Only if BOTH of the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines:

- to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
- assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The Plan does not cover ANY of the following services associated with a clinical trial:

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

Telemedicine

The Plan offers MDLIVE telemedicine services. Through this service, participants can connect with a nationwide network of board certified **physicians** and licensed therapists through secure video or telephone. This service is available 24 hours per day, and users may call from any location. Visit the *www.myCigna.com* website for further information.

Genetic Testing

The Plan covers genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease, subject to these conditions:

- The person has symptoms or signs of a genetically-linked inheritable disease;
- The person is determined to be at risk for carrier status, and the determination is supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact the clinical outcome; or
- The therapeutic purpose is to identify a specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

The Plan covers pre-implantation genetic testing (genetic diagnosis before embryo transfer) when either parent has an inherited disease or is a documented carrier of a genetically linked inheritable disease.

Testing of a family member may be covered under the following conditions:

- The condition meets the criteria for genetic testing under the Cigna HealthCare coverage policy;
- The family member is a better alternative than the patient for clinical reasons and a negative test would preclude unnecessary testing of the patient; and
- Testing the family member is being done for the primary purpose of identifying or excluding a risk for the patient.

The Plan covers genetic counseling for someone who (1) is undergoing approved genetic testing, or (2) has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to three (3) visits per year for both pre- and post-genetic testing.

Coverage for services related to genetic testing may require prior authorization. Your network **physician** will assist you in obtaining the authorization. If you are receiving care out-of-network, contact the Healthy Life Personal Health Team at 1.888.992.4462 for assistance.

Nutritional Evaluation

The Plan covers individualized nutritional evaluation and counseling that is (1) **medically necessary** for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program, (2) prescribed by a **physician** or physician extender (a nurse practitioner or physician assistant), and (3) provided by a licensed health-care professional (e.g., a registered dietician) covered under the Plan.

Conditions for which nutritional evaluation and counseling may be considered **medically necessary** include, but are not limited to:

- Anorexia nervosa/bulimia,
- Celiac disease,
- Cardiovascular disease,
- Crohn’s disease (CD),
- Diabetes mellitus (DM),
- Disorders of metabolism (e.g., inborn errors of metabolism, inherited metabolic diseases, amino acid disorders),
- Hyperlipidemia,
- Hypertension,
- Liver disease,
- Malabsorption syndrome,
- Metabolic syndrome X,
- Multiple or severe food allergies,
- Nutritional deficiencies,
- Obesity (i.e., body mass index (BMI) > 30 kg/m2 or >95th percentile),
- Post-bariatric surgery,
- Prediabetes,
- Renal failure, and

- Ulcerative colitis (UC).

The Plan does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program because they are not considered to be **medically necessary**.

Conditions for which nutritional evaluation and counseling are not considered to be **medically necessary** include, but are not limited to:

- Attention-deficit/hyperactivity disorder (ADHD),
- Chronic fatigue syndrome (CFS),
- Idiopathic environmental intolerance (IEI), and
- Multiple food and chemical sensitivity.

PRESCRIPTION DRUG BENEFITS

This section describes the prescription drug benefits available under the Plan. Except for **preventive generic drugs** and other medications covered under the Patient Protection and Affordable Care Act (such as contraceptives and certain other over-the-counter medications), once you have met your Plan **deductible**, you pay **coinsurance** for each eligible prescription. Your **coinsurance** amount depends on whether you receive a generic drug, preferred brand name drug or a non-preferred brand name drug, as indicated on the **drug list**. Your **coinsurance** will be higher for a brand name drug, regardless of whether a generic equivalent is available. Your cost will be lowest with a generic drug and highest with a non-preferred brand name drug. Your cost may also be affected by whether you fill your prescription at an in-network **pharmacy**, an out-of-network **pharmacy** or through the Cigna Mail Order Prescription Program. More details are provided in the sections that follow.

Covered Expenses

The Plan covers charges for **medically necessary** prescription drugs or related supplies ordered by a **physician** and filled under:

- The Pharmacy Program, which covers prescriptions filled either through the Cigna Pharmacy Services network or outside the network; and
- The Cigna Mail-Order Prescription Program which uses Cigna Home Delivery Pharmacy.

You may fill a 90-day supply of maintenance medication (typically medications taken on a regular basis) at a participating "Cigna 90-now" pharmacy. See "Exclusive Home Delivery" for further details.

The Plan also covers **medically necessary** prescription drugs and related supplies prescribed by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

If a prescription that is part of **emergency services** cannot reasonably be filled by a participating **pharmacy**, the Plan will cover the prescription as if it were filled by a participating **pharmacy**.

Dispensing Limits

Each prescription order or refill is limited:

- Up to a consecutive 30-day supply, at a **pharmacy**, unless limited by the drug manufacturer's packaging; or
- Up to a consecutive 90-day supply by Cigna Home Delivery Pharmacy , unless limited by the drug manufacturer's packaging; or
- Up to a dosage and/or dispensing limit as determined by the **Pharmacy & Therapeutics (P&T) Committee**.

Drug List

The **drug list** is located on *www.myCigna.com*. It provides a comprehensive list of generic and brand name drugs covered by the Plan, and indicates whether the drug is considered generic, preferred brand or non-preferred brand and its **coinsurance** level. The drug list corresponds with the Cigna Value Prescription Drug List with certain customized enhancements to cover two additional classes of drugs: (1) allergy drugs and (2) proton pump inhibitors (PPI) that treat stomach ulcers and heartburn.

The Plan covers prescribed medications, including certain prescribed over-the-counter (OTC) medications, required to be covered under the Patient Protection and Affordable Care Act at 100 percent when a network **pharmacy** is used. Coverage of OTC and other preventive medications may change as additional regulations are issued. You must have a prescription from your doctor in order for the covered OTC medication to be covered at 100 percent. A list of No Cost Preventive Medications covered under the Patient Protection and Affordable Care Act is available on the *Your Cigna Life* website under (*Health & Well-Being>Health Benefits>Medical>Prescription drug coverage*). For the most up-to-date list of preventive care OTC and other medications that are covered under the Patient Protection and Affordable Care Act, go to https://www.healthcare.gov/what-are-my-preventive-care-benefits/.

All drugs newly approved by the FDA are designated as either non-preferred or not on the **drug list** until the **P&T Committee** clinically evaluates the prescription drug. The **P&T Committee** will review prescription drugs that represent an advance over available therapy according to the FDA within six months after FDA approval. The **P&T Committee** will not review prescription drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed by **Cigna HealthCare** to make an interim decision on the merits of a prescription drug.

Dispense As Written

If you fill a prescription for an otherwise covered brand name drug, the Plan will pay benefits up to the cost of the generic equivalent, even if "dispense as written" is indicated on the prescription. You are responsible for paying the difference in cost between the brand name drug and the generic equivalent, plus any coinsurance applicable to the generic drug.

Prior Authorization

The Plan covers certain prescription drugs and related supplies only if your **physician** obtains authorization before prescribing them. 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.

Prescriptions that require prior authorization are noted on the **drug list** at *www.myCigna.com*. If your **physician** wishes to request coverage for prescription drugs or related supplies for which prior authorization is required, your **physician** may call the Customer Service Center at 1.888.99Cigna (1.888.992.4462) or fax the appropriate prior authorization form to the **claims administrator**. Your **physician** should make this request before writing the prescription.

Cigna HealthCare reviews and makes a determination on the prior authorization request within 120 hours (72 hours if the request involves an expedited determination as described under "Medical Necessity Determinations"). If the request is approved, **Cigna HealthCare** will contact your **physician** confirming the approval. The authorization will be processed in the 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 the 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. If you do not obtain prior authorization before going to the **pharmacy**, the pharmacist will charge you the full cost of the medication or, in some cases, may not be able to fill the prescription.

If the prior authorization request does not meet **Cigna HealthCare's** criteria, it will send a letter to your **physician** within 4 business days of the initial request, with a copy to you, explaining why the request was not approved and how to appeal the decision.

If you have questions about a specific prior authorization request, you should call the Customer Service Center at 1.888.99Cigna (1.888.992.4462).

Pharmacy Program

You may have your prescription filled at any **pharmacy** but each prescription is limited to no more than a 30-day supply. If you fill your prescription at a **pharmacy** that participates in the **Cigna** network, you pay any applicable **coinsurance** or **deductible** at the time of purchase. You do not need to file a claim form.

If you fill your prescription at a **pharmacy** that does not participate in the **Cigna** network, you pay the full cost at the time of purchase. You must submit a claim form to be reimbursed. Claim forms are available at the *Your Cigna Life* website under *Self Service>Employee Self Service>Forms/Tools & Resources*.

Mail-Order Prescriptions Using Cigna Home Delivery Pharmacy

The Plan covers prescriptions filled by mail-order through Cigna Home Delivery Pharmacy Service. This program allows you to order up to a 90-day supply of most prescription drugs.

Most prescription drugs are available through mail-order. It takes 15 or 20 days to fill a prescription, unless there are mail delays. If you need a supply of medication while waiting for your mail-order prescription to arrive, ask your **physician** for two prescriptions so you can also get a small supply of the medication from your local **pharmacy**.

Preventive Generic Medication Paid in Full Through Cigna Home Delivery Pharmacy

The cost of **preventive generic drugs** is paid in full by the Plan when obtained through Cigna Home Delivery Pharmacy. **Preventive generic drugs** that are paid in full when obtained through Cigna Home Delivery Pharmacy are identified on the **drug list** located on *www.myCigna.com*. A list is also available on the *Your Cigna Life* website under *Health & Well-being>Medical>Prescription drug coverage*.

Certain Preventive Preferred Brand-Name Medication Deductible Waived Through Cigna Home Delivery Pharmacy

The deductible is waived for preventive preferred brand-name medications in certain classes (insulin and asthma medications) without a generic alternative when obtained through Cigna Home Delivery Pharmacy. A list is available on www.Cigna.com/healthylife.

Specialty Medication Through Cigna Home Delivery Pharmacy

Specialty medications, injectables and oral, are used to treat a number of conditions, including anemia, arthritis, cancer, growth issues, infertility, hepatitis C and multiple sclerosis. Cigna Home Delivery Pharmacy provides these medications through its Specialty Pharmacy Program. You may receive up to a 30-day supply of medication. Alcohol pads, needles, syringes, and sharps kits are provided without charge, if requested when placing an order. Specialty drugs obtained through this program are subject to the Plan **deductible**, prescription drug **coinsurance** levels and a specialty medication cost limit. See the charts in Appendix I. Specialty medications are covered only when purchased through Cigna Home Delivery Pharmacy.

Injectable infertility drugs and any injectable drugs that require physician supervision are not typically considered self-administered drugs obtained through Cigna Home Delivery Pharmacy under the Specialty Prescription Drug Program. The following are examples of **physician** supervised drugs considered medical services covered by the Plan and subject to pre-certification requirements: injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables, and endocrine and metabolic agents.

Exclusive Home Delivery

Prescriptions for maintenance medications taken on an ongoing or indefinite basis are to be filled through Cigna Home Delivery Pharmacy or at a "Cigna 90-now" participating retail pharmacy. Enrollees may receive a 90-day supply of maintenance medication at a "Cigna 90-now" pharmacy. A list of maintenance medications is available on the *Your Cigna Life* website under *Health & Well-being>Medical>Prescription drug coverage*.

Prescription Drug Exclusions

The Plan does NOT cover the following types of drugs or medicines and related expenses:

- Drugs available over the counter that do not require a prescription by federal or state law other than those required to be covered as preventive items under the Patient Protection and Affordable Care Act;
- Any drug that is a pharmaceutical alternative to an OTC 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**;
- Any drugs that are experimental or investigational as described under the Medical "Exclusions" section;
- FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than related supplies;
- Implantable contraceptive products;
- Dietary supplements, and fluoride products (except as required to be covered as preventive items under the Patient Protection and Affordable Care Act);
- Drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- Diet pills or appetite suppressants (anorectics);
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- Replacement of prescription drugs and related supplies due to loss or theft;
- Drugs used to enhance athletic performance;
- Drugs which are to be taken by or administered to you while you are a patient in a licensed **hospital**, **skilled nursing facility**, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- Vitamin pills (not including prescription pre-natal vitamins); and
- Prescriptions more than one year from the original date of issue.

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

MENTAL HEALTH & SUBSTANCE ABUSE

The Plan covers mental health and substance abuse services as described in this section. In addition, the Cigna Employee Assistance Program ("EAP") (formerly called the Life Coaching Program) provides support for mental health and substance abuse issues. You do not have to be enrolled in the Cigna Medical Plan to use it.

The Employee Assistance Program (EAP)

The EAP is a resource for you and members of your household for mental health or substance abuse concerns. If you or a household member is struggling with a personal problem, you may call the EAP at 1.888.992.4462, 24 hours a day, seven days a week. You do not need to be enrolled in the Cigna Medical Plan to use the EAP.

The EAP provides assessment and problem resolution and is focused on helping you find appropriate care when you need it. The EAP provides up to five visits for each issue at no cost to you or members of your household. When you call the EAP, you will be referred to an EAP counselor for an assessment or, in the case of a more acute condition, a **specialist** within the **Cigna** network. Many situations can be resolved through the EAP alone. However, if you need additional assistance, the EAP will provide a referral to the appropriate professional for ongoing care. All information you provide to the EAP is treated as confidential.

If the EAP coverage ends due to the termination of your **Cigna** employment (for reasons other than gross misconduct as defined by **Cigna)**, the EAP services will be available to you and members of your household for 18 months from the date of the termination.

If the EAP coverage for a member of your household terminates due to your death, your divorce or legal separation, the dissolution of your **partnership**, or when coverage terminates for your dependent, the EAP services will be available for 36 months from the date of the event.

Mental Health and Substance Abuse Services

The Plan covers mental health and substance abuse care services as described in this section and in the charts in Appendix I.

- Mental health services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. Treatment of any physiological conditions related to mental health is not considered to be mental health services.
- Substance abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. Treatment of any physiological conditions related to rehabilitation services for alcohol, drug abuse or addiction is not considered to be substance abuse care services.

Inpatient Mental Health Services

The Plan covers services that are provided by a **hospital** while a patient is confined in a **hospital** for the treatment and evaluation of mental health. Inpatient mental health services include (1) partial hospitalization sessions and (2) mental health residential treatment services when a patient is a registered bed patient on the recommendation of a **physician**.

- Partial hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.
- Mental health residential treatment services are services provided by a **hospital** or mental health residential treatment center for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute mental health conditions.
- A mental health residential treatment center is an institution that:
    - 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 by the appropriate legally authorized agency as a residential treatment center.

Inpatient mental health services are provided in accordance with the Mental Health Parity Act of 1996, as amended.

Outpatient Mental Health Services

The Plan covers services of health care professionals who are qualified to treat mental health when treatment is (1) provided on an outpatient basis, while a person is not an inpatient in a **hospital**, and (2) 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;
- Acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention); and
- Outpatient testing and assessment.

A mental health intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed mental health program. Intensive outpatient therapy programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Abuse Rehabilitation Services

The Plan covers services for rehabilitation while a patient 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 (1) partial hospitalization sessions and (2) substance abuse residential treatment services when a patient is a registered bed patient on the recommendation of a **physician** as follows:

- Partial hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.
- Substance abuse residential treatment services are services provided by a **hospital** or substance abuse residential treatment center for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute substance abuse conditions.
- A substance abuse residential treatment center is an institution that:
    - 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 by the appropriate legally authorized agency as a residential treatment center.

Outpatient Substance Abuse Rehabilitation Services

The Plan covers services for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while a person is not an inpatient in a **hospital**, including outpatient rehabilitation in an individual, group or a substance abuse intensive outpatient therapy program.

A substance abuse intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. Intensive outpatient therapy programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours per week.

Substance Abuse Detoxification Services

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

Exclusions

The Plan does NOT cover the following mental health and substance abuse services:

- Any court-ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless **medically necessary** and otherwise covered under the Plan;
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders;
- Counseling for activities of an educational nature;
- Counseling for borderline intellectual functioning;
- Counseling for occupational problems;
- Counseling related to consciousness raising;
- Vocational or religious counseling;
- I.Q. testing;
- Custodial care, including but not limited to geriatric day care;
- Psychological testing on children requested by or for a school system; and
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

WHAT'S NOT COVERED- ADDITIONAL EXCLUSIONS AND GENERAL LIMITATIONS

The following medical expenses are NOT **covered expenses** under the Cigna Medical Plan:

- Charges for services you receive before Plan coverage is effective.
- Charges above (1) the **maximum reimbursable charge** level, (2) the amount allowed by Medicare, or (3) specified coverage limitations.
- Charges for services for or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for services for or in connection with an injury or sickness which is due to war, declared or undeclared.
- Charges for services to the extent that you or your **covered dependent** is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- Charges for court-ordered treatment or hospitalization, unless such treatment is prescribed by a **physician** and listed as covered in this Plan.
- Charges for services provided at no cost under any federal, state or local law, including Medicare.
- Charges made by any covered health professional who is a member of your family or your **covered dependent's** family.
- Charges that would not have been incurred if the person had no medical insurance.
- Charges for care for health conditions that state or local law requires to be treated in a public facility.

- 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.
- Charges for blood administration aimed at general improvement in physical condition.
- Charges for biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Unless otherwise covered in this Plan, charges for reports, evaluations, physical examinations, or hospitalization not required for health reasons. This exclusion includes, but is not limited to, exams for employment, insurance or a government license, and court-ordered, forensic or custodial evaluations.
- Charges for any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Charges for services that are not medical care, such as filling out claim forms.
- Charges for treatment, surgery, or services that are not **medically necessary** as determined by **Cigna HealthCare** or the **claims administrator** according to guidelines established by **Cigna HealthCare**.
- Except as provided under "Clinical Trials" above, charges for medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, drug therapies, devices, procedures and treatments that are experimental, investigational, or unproven, as determined by **Cigna HealthCare** to be:
    - Not demonstrated through existing peer-reviewed, evidence based, scientific literature to be safe and effective for treating or diagnosing the condition for which its use is proposed; or
    - Not approved by the FDA or other appropriate regulatory agency to be lawfully marketed for the proposed use; or
    - The subject of review or approval by an Institutional Review Board for the proposed use; or
    - The subject of an ongoing phase I, II or III clinical trial.
- Charges excluded as a result of failure to comply with precertification, continued stay review, case management or other certification or preauthorization requirements.
- Charges for consumable medical supplies (such as bandages and elastic stockings), except for urinary catheters and ostomy supplies. 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" sections of the SPD.
- Charges for 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 the Plan.
- Charges for services, including maternity-related services, rendered after coverage terminates, except for those services provided on account of qualifying total disabilities.
- Charges for, or related to, custodial care, respite care, education or training.
- Charges for which you have no legal obligation to pay.
- Charges for which payment is unlawful where you or your **covered dependent** lives when the expenses are incurred.
- Charges for a stay in a **hospital** owned or operated by the U.S. Government or incurred while performing services for the U.S. Government, if such charges are directly related to a military service-connected illness or injury.

- Charges for private **hospital** rooms and/or private duty nursing except as provided under the "Home Health Services" provision.
- Charges for or in connection with routine refractions (except as noted in the charts in Appendix I), eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- Charges for or in connection with the examination for, prescription of, purchase or replacement of eyeglasses or contact lenses, except the charge for the first pair of eyeglasses, lenses, frames or contact lenses following keratoconus or cataract surgery.
- Charges for eye examinations required as a condition of employment or which an employer is required to provide under a collective bargaining agreement.
- Charges for eye examinations required by law, safety glasses, or lenses required for employment.
- Charges for routine ear examinations, except as part of preventive care.
- Charges for hearing aids over $1,500 per hearing aid and/or charges for any hearing aid in excess of the maximum of two hearing aids every 36 months. A hearing aid is any device that amplifies sound.
- Charges for genetic screening or pre-implantation 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.
- Charges for dental implants for any condition.
- Charges related to 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.
- Charges for therapy or treatment services to improve general physical condition or for the purpose of enhancing job, school, athletic or recreational performance. This exclusion includes, but is not limited to, routine, long term or maintenance care which is provided after resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Charges related to all medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index parameters of the National Heart, Lung and Blood Institute guidelines, is covered if the services are demonstrated through peer-reviewed medical literature and scientifically-based guidelines, to be safe and effective for the treatment of the condition.
- Charges for membership or fees associated with health clubs and weight-loss programs.
- Charges for massage therapy.
- Charges related to court-ordered treatment or hospitalization, unless such treatment is deemed **medically necessary** and otherwise covered.
- Charges related to artificial aids including, but not limited to, orthotic shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers, orthoses primarily used for cosmetic rather than functional reasons, corrective orthopedic shoes or arch supports, elastic stockings, garter belts, corsets or dentures.
- Charges made for, or in connection with, tired, weak or strained feet for which treatment consists of routine foot care including, but not limited to, the removal of calluses or corns or the trimming of nails. However services associated with foot care for diabetes and peripheral vascular disease are covered when **medically necessary**.
- Charges for cosmetics, dietary supplements, health and beauty aids and nutritional formulae. However, nutritional formulae is covered when required for the treatment of inborn errors of metabolism or inherent metabolic disease (including disorders of amino acids and organic acid metabolism) or enteral feeding for which

the nutritional formulae (a) can be dispensed only through a **physician's** prescription under state or federal law and (b) is **medically necessary** as the primary source of nutrition.

- Charges for those items cited as not covered in the section on "Prescription Drugs."
- Charges for non-medical counseling or related services including, but not limited to, **custodial services**, education or training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back-to-school counseling, work hardening, driving safety and services, training, educational therapy or other non-medical related services for learning disabilities or developmental delays.
- Charges for accupressure, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Charges in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth; (b) charges made by a **hospital** for **bed and board** or necessary services and supplies; (c) charges made by a **free-standing surgical facility** or the outpatient department of a **hospital** in connection with surgery.
- Except as described under "Global Medical Services," charges incurred outside the United States or Canada.
- Charges for 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.
- Charges for telephone, e-mail and Internet consultations and telemedicine other than MDLive.

HEALTH MANAGEMENT RESOURCES

The following section provides detailed information about resources that provide personalized support to help you manage your health.

Healthy Life Personal Health Team

The **Healthy Life Personal Health Team** provides education and support to keep you healthy, help you reduce risks caused by lifestyle choices and help you reach your health-related goals. It can help you identify treatment options to discuss with your **physician** and can refer you to the appropriate care/disease management program when you have a chronic or acute condition.

The **Healthy Life Personal Health Team** includes registered **nurses**, health educators, behavioral clinicians, nutritionists and other clinical resources to meet the various needs of the individuals that they serve. You will be assigned a coach whose expertise most closely aligns with your health-related concerns and issues.

A Healthy Life Personal Health coach may contact you about topics related to your **health assessment**, care alternatives or resources available to help you manage your condition. You may speak with a Healthy Life Personal Health coach by calling 1.888.99Cigna (1.888.992.4462).

The 24-Hour Health Information Line

You can call the 24-Hour Health Information Line at 1.888.99Cigna (1.888.992.4462) to speak with a registered **nurse** any hour of the day or evening to get:

- Answers to your health questions;
- Help in choosing the most appropriate care in the case of an emergency;
- Help in locating nearby participating health professionals when you are away from home; or

- Information from hundreds of pre-recorded programs or tapes in the Health Information Library covering a wide variety of health topics.

Chronic Condition Support & Other Coaching Programs

The Chronic Condition Support Program provides individualized care support and educational materials to you and your doctor for the following conditions:

- Asthma;
- Chronic Obstructive Pulmonary Disease (emphysema, chronic bronchitis);
- Coronary Artery Disease;
- Depression (anxiety, bipolar disorder);
- Diabetes;
- Heart Disease (heart failure, angina, acute myocardial infarction);
- Low Back Pain;
- Metabolic Syndrome/Weight Complications;
- Osteoarthritis;
- Peripheral Artery Disease;
- Childhood Asthma; and
- Childhood Diabetes.

The Plan also provides a special care coaching program that focuses on pregnancies called Healthy Pregnancies, Healthy Babies and support services for many other conditions.

In addition, Lifestyle Management Programs provide help with stopping tobacco use, weight loss/management and stress. Online Health Coaching is also available for sleep, nutrition, stress and physical activity.

Healthy Life Care Centers (Onsite Clinics)

In certain locations, **Cigna** provides access to an onsite clinic staffed by a **nurse** practitioner and medical assistant. These Healthy Life Care Centers are open to all **Cigna** employees and in certain locations, **spouses/partners** and dependent children ages 13 and older may also access the clinic. A list of Healthy Life Care Center locations and contact information is available on the *Your Cigna Life* website under *Health & Well-being>My Healthy Life>Wellbeing Center*. Visit or contact your local clinic directly for information about clinic hours and to schedule an appointment.

The Healthy Life Care Centers generally provide the following services:

- Routine medical care;
- Urgent care;
- Chronic condition management;
- Health coaching;
- Care coordination with your doctor or other specialists;
- Travel medicine;
- Ergonomic Assessments;
- Occupational medicine;

- Physicals and biometric screenings; and
- Phlebotomy services (drawing blood).

The Onsite Clinics provide preventive care services at no cost to **Cigna** employees, and in certain locations **spouses/partners** and dependent children ages 13 and older. Non-preventive care services may be provided for a fee.

Federal regulations require the Onsite Clinics to charge a fee for non-preventive care services provided to **Cigna** employees enrolled in the HSA option of the Medical Plan. Please visit or contact your Onsite Clinic for more information.

If your employment with **Cigna** terminates (for reasons other than gross misconduct as defined by **Cigna)** or due to the reduction of your work hours, onsite clinic services will be available to you for 18 months from the date of termination or reduction in hours.

ACCESSING CARE

The following sections provide detailed information about how your Plan coverage works.

Your Identification Card

You and your **covered dependents** will each receive Plan identification (ID) cards approximately 10 business days after you enroll in the Cigna Medical Plan. You may receive new cards at the beginning of new **plan years**. Your ID card contains important information, including your ID number and instructions on what to do in an emergency. Remember to carry your card with you at all times and present it each time you need medical care or a prescription.

Network Care

Unless you live in an area where a special network option applies, the Plan uses the Cigna Health Open Access Plus (OAP) with the CareLink national network of **physicians**, **hospitals**, and **other health care professionals/facilities**. Under the OAP network, you may use any network health care professional or facility nationwide, and you do not need referrals for **specialists**. The network directory is available online at *www.myCigna.com* under the tab, *Find a Doctor, Dentist, or Facility* or by calling the Customer Service Center at 1.888.99Cigna (1.888.992.4462).

When you receive services in-network your cost will generally be lower because **Cigna HealthCare** negotiates discounts with network health care professionals and facilities and the Plan generally pays a greater share of the costs than if you receive out-of-network care.

Special Network Plan Options

LocalPlus Network Options

If you live in certain geographic areas where the LocalPlus Network has been established and is made available by Cigna Healthcare (except for Massachusetts and Rhode Island), you may be covered by an HSA LocalPlus Plan option. LocalPlus Plan options have special network features that work differently than the standard in-network and out-of-network coverage described throughout this SPD.

In the applicable geographic area for the LocalPlus option, in-network coverage is available only through a separate network of **physicians**, **hospitals** and **other health care professionals/facilities**. This LocalPlus network is different than the Cigna Healthcare Open Access Plus network. If you receive care from a **physician**, **hospital** or **other health care professional/facility** that is located in the applicable LocalPlus geographic area but does not participate in the LocalPlus network (even if the health care professional participates in the Cigna Healthcare Open Access Plus network), your services will be covered under the rules that apply to out-of-network services.

Outside of the LocalPlus geographic area, the Cigna Healthcare Open Access Plus network applies and services received from a **physician**, **hospital** or **other health care professional/facility** that participates in the Cigna Healthcare Open Access Plus network will be covered under the rules that apply to in-network services for the Open Access Plus Plan options.

A list of participating LocalPlus network health care professionals is available online at *www.myCigna.com* under the tab, *Find a Doctor, Dentist, or Facility* or by calling the Customer Service Center at 1.888.99Cigna (1.888.992.4462).

Out-of-Network Care

The Plan provides coverage for **hospital**, **physician** and related services that you receive out-of-network. You can see any doctor you choose, even one who is not in your network. Your costs will be higher for out-of-network services and you may have to file claims.

When you use out-of-network services, remember:

- You may have to pay higher out-of-pocket costs.
- Your out-of-network coverage is lower than your in-network benefits and some out-of-network services may not be covered at all.
- You may have to file claims.
- You are responsible for all authorizations.

Out-of-network services are covered only up to the amount of **maximum reimbursable charges**. **Cigna HealthCare** determines these amounts by computing what area **physicians** charge for specific services. These are the maximum amounts the Plan pays for out-of-network care. Any charges above that maximum are your responsibility. You can call the Customer Service Center at 1.888.99Cigna (1.888.992.4462) for more information on the **maximum reimbursable charges** for a particular procedure or treatment.

Opportunity to Select a Primary Care Physician

The Plan does not require that you select a **primary care physician** or obtain a referral from a **primary care physician** in order to receive all benefits available to you under this Plan. A **primary care physician** may serve an important role in meeting your health care needs by providing or arranging for your medical care. For this reason, **Cigna HealthCare** encourages the use of **primary care physicians** and provides you with the opportunity to select one for yourself and your **covered dependents**. If you choose to select a **primary care physician**, the **primary care physician** you select for yourself may be different from the **primary care physician** you select for each of your **covered dependents**. You have the right to designate any **primary care physician** who participates in the network and who is available to accept you or your **covered dependents**.

You can find a list of the participating **primary care physicians** on *www.myCigna.com* under the tab, *Find a Doctor, Dentist or Facility*, or call the Customer Service Center at 1.888.99Cigna (1.888.992.4462) for assistance. The **Cigna** network of **primary care physicians** generally includes family and general practitioners. For children, you may designate a pediatrician as the **primary care physician**.

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the Plan or from any other person (including a **primary care physician**) in order to obtain access to obstetrical or gynecological care from a health care professional in the 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 the *Find a Doctor, Dentist or Facility* tab on the *www.myCigna.com* website or call the Customer Service Center at 1.888.99Cigna (1.888.992.4462).

Network Specialists

If you or your doctor decides that you need specialized care, you may see any **specialist** in or out of the Open Access Plus national network. Plan benefits are higher and your out-of-pocket costs are lower if you choose a network **specialist**.

Cigna Care Network Designation – Open Access Plus

Your Open Access Plus in-network Plan benefit will be even higher if you use a **specialist** or **primary care physician** with a Cigna Care Network designation. These physicians are designated with a tree of life logo in the directory, which can be accessed through *www.myCigna.com*. The Cigna Care Network designation does not apply to all specialties; for some specialties there may be no Cigna Care designated **specialist**. For specialties that are designated, a Cigna Care **specialist** may not be available near to you. In some locations, no Cigna Care designated physicians are available. The Cigna Care Network designation does not apply to the LocalPlus network.

Centers of Excellence

When you require care in a **hospital**, you may use a **hospital** in or out of your network. Plan benefits are higher and your out-of-pocket costs are lower when you receive your care in-network.

Hospitals that have received the highest rating for quality and cost from **Cigna HealthCare** for certain common procedures are identified as **Centers of Excellence** in the online health care professional directory on *www.myCigna.com*. More information about **Centers of Excellence** is available on *www.myCigna.com* under the tab *Find a Doctor, Dentist or Facility.*

Global Medical Services

Travel Outside the U.S.

The Plan covers charges for **covered services** incurred outside the United States and Canada. If you are traveling on **Cigna** business outside the U.S. and are covered under another **Cigna-** sponsored plan that provides medical benefits for **Cigna** employees traveling abroad on business, your benefits under the Cigna Medical Plan will be coordinated with that plan and it will be considered the primary plan that pays first. See "Coordination of Benefits".

Global Medical Tourism

Through the Global Medical Tourism Program, you may choose to have hip or knee replacement procedures performed at a designated **hospital** abroad. Global Medical Tourism must be authorized in advance by **Cigna HealthCare**.

A procedure performed under Cigna's Global Medical Tourism Program is considered network care and the cost for the surgery and associated post operative care counts toward meeting your annual network **deductible** and **out-of-pocket maximum**, provided prior authorization is received from **Cigna HealthCare**. If you receive treatment under the Global Medical Tourism Program, **Cigna** will credit an additional $2,500 to your HSA to help pay your share of the medical expenses.

The Plan will pay air fare (coach class), food (up to $50/day/per person) and lodging expenses for the person receiving the surgery and one companion, up to a maximum allowance of $7,500 per person. (This would cover travel and lodging expenses for 2 weeks, which is a typical length of stay for the surgery and recovery.) A companion includes your **spouse** or **partner**, a member of your family, a legal guardian or any person not related to the person having surgery, but actively involved as a caregiver.

A concierge facilitator will be assigned to assist with making travel arrangements, selecting a surgeon from a **Cigna-**approved panel of overseas **physicians** and scheduling the appointment. For more information, contact the Healthy Life Personal Health Team at 1.888.992.4462.

Emergency Care

This section describes how the Plan works in situations that require emergency care. See "Urgent Care" for information about less-serious situations that may still require prompt medical attention.

In an emergency always seek medical care immediately. Go directly to the nearest emergency room or call 911. Some examples of **emergency medical conditions** are loss of consciousness, seizures, severe pain, uncontrolled bleeding, lack of responsiveness, sudden paralysis or slurred speech, chest pains, shortness of breath, broken bones, inability to swallow, and suspected overdose of medication or poisoning.

As long as your care meets the Plan's definition of **emergency services**, you do not need any pre-authorization for it. The Plan covers **emergency services** provided out-of-network as if the services were provided in-network, but out-of-network services will cost you more because **Cigna** has not contracted with out-of-network health professionals or facilities to provide lower, discounted charges for the services you receive. **Emergency services** are subject to the **deductible** and you will have to pay the in-network **coinsurance** amount. In the case of care received out-of-network, you also will be responsible for any amount over the **maximum reimbursable charge** covered by the Plan.

Call Your Physician

If you have any questions about your situation, you should call your **physician** or the **physician** covering his or her calls.

The 24-Hour Health Information Line

The **Cigna HealthCare** Health Information Line is available 24 hours a day, any day of the year. You may call 1.888.99Cigna (1.888.992.4462) to speak with a **nurse** for detailed answers to your health care questions and for assistance locating the nearest medical facility where you can receive care.

If You Need to Be Hospitalized

If you are taken to a **hospital** because of a life-threatening emergency, be sure to show your ID card. Contact your **physician** and the Customer Service Center at 1.888.99Cigna (1.888.992.4462) within 48 hours after admission so arrangements can be made for your continued care.

Be sure to follow these procedures carefully. Otherwise, payment to the **hospital** for **emergency services** may be denied or reduced. If you go to an out-of-network **hospital** or other facility, you also may be required to pay the full cost of the emergency care and then file a claim for reimbursement from the Plan.

Urgent Care

Many situations are not emergencies but still require immediate medical attention. In an urgent medical situation symptoms occur unexpectedly and delaying medical treatment may cause serious medical problems. Some examples of **urgent care** situations are ear infections, sprains, minor burns, high fevers, vomiting, prolonged diarrhea, and urinary tract infections.

Call Your Physician

Your **physician** will tell you what you can do at home or tell you where to go to receive the most appropriate care.

Call the 24-Hour Health Information Line

You can call 1.888.99Cigna (1.888.992.4462) 24 hours a day, seven days a week to speak with a **nurse** who can answer your health care questions, provide helpful homecare suggestions or direct you to the nearest medical facility.

Care Away From Home

The Plan covers you for treatment of an illness or injury if you are away from home. You can call the 24-Hour Health Information Line at 1.888.99Cigna (1.888.992.4462) 24 hours a day, seven days a week to speak to a **nurse** who will answer your health care questions, provide helpful self-care suggestions or assist you in arranging care.

If, while away from home, you are admitted to the **hospital** or require care beyond an initial emergency visit, you must call your **physician** and the Customer Service Center at 1.888.99Cigna (1.888.992.4462), within 48 hours so arrangements can be made for your continued care. If you cannot call, someone must call for you.

When you receive medical care from out-of-network health care professionals, you may be responsible for paying for medical treatment when you or your **covered dependent** receives it. Be sure to keep a copy of the bill for your records and file a claim with the Plan for reimbursement.

If You Need to Be Hospitalized - Authorization/Certification Requirements

If your **physician** recommends that you enter a **hospital**, extended care facility or rehabilitation center, your admission must be authorized in advance or the amount the Plan pays will be reduced or denied. Different processes apply depending on whether you receive care at an in-network or out-of-network **hospital** or facility.

Prior Authorization - For In-Network Care

A network **physician** must receive approval – called "prior authorization" – from **Cigna HealthCare** in order for certain services and benefits to be covered under the Plan. The network **physician** must receive the prior authorization before the services are provided.

Services that require prior authorization include, but are not limited to:

- Inpatient **hospital** services;
- Inpatient services at any participating **other health care facility**;
- Residential treatment;
- Nonemergency ambulance; or
- Transplant services.

Your network **physician** obtains the authorization from **Cigna HealthCare** for in-network care.

Certification Requirements – For Out-of-Network Care

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

You must follow a process – called "pre-admission certification (PAC)" and "continued stay review (CSR)" – to obtain certification of the **medical necessity** and length of a **hospital** stay when you require treatment in an out-of-network **hospital:**

- As a registered bed patient;
- For a partial hospitalization for the treatment of mental health or substance abuse; and
- For mental health or substance abuse residential treatment services.

You should request PAC before any non-emergency treatment in an out-of-network **hospital**. If you are admitted to the **hospital** as an emergency admission, you should contact the review organization within 48 hours after the admission. If you need to stay in the **hospital** or facility beyond the authorized number of days, you should request CSR before the end of the length of stay that has been approved.

If you fail to follow these PAC/CSR requirements, penalties will apply. See the "Out-of-Network Hospital Pre-Admission Certification and Continued Stay Review Requirements" chart.

The Plan will not treat any expenses for which the Plan denies or reduces payment because you fail to meet these out-of-network PAC/CSR requirements as expenses you have incurred for any other purpose under the Plan, except for the "Coordination of Benefits" section.

OUT-OF-NETWORK HOSPITAL PRE-ADMISSION CERTIFICATION AND CONTINUED STAY REVIEW REQUIREMENTS

	Cigna HealthCare
Who to Call	1.888.99Cigna (1.888.992.4462)
When to Call	
Non-Emergency	10 days before admission
Emergency	Within 48 hours after admission

Maternity[1]	Sixth month of pregnancy and at delivery
Penalties You Pay If You Don't Call	You pay 50% of covered charges
Penalties If You Enter the **Hospital** After Your Admission Is Not Approved	No coverage
Penalties If Your **Hospital** Stay Is Longer Than Authorized	No coverage

[1] Under Federal law, a medical plan may not limit the length of **hospital** stay for the mother or the newborn child in connection with childbirth to a period of less than 48 hours following a normal, vaginal delivery, or less than 96 hours following a caesarean section. Plan benefits for longer stays require preauthorization.

Maternity Care

You and your **covered dependents** must follow the preauthorization or PAC/CSR procedures for maternity care just as you would any other type of inpatient **hospital** care. Your network **physician** obtains authorization for network care. You are responsible for obtaining hospitalization pre-certification (PAC) and continued stay authorization (CSR) for any out-of-network care. Follow these steps:

- Contact **Cigna HealthCare** to apply for pre-certification by the end of the sixth month of pregnancy. Contact the review organization earlier about potential high risk situations that may require additional assistance.
- After the birth, contact **Cigna HealthCare** again to pre-certify a reasonable length of stay based on the mother's condition following the delivery.
- If the mother must remain in the **hospital** beyond the number of days authorized, contact the review organization to request continued certification of the stay.
- If the new baby must remain in the **hospital** beyond the mother's release date, contact the review organization so that an appropriate length of stay and treatment plan for the baby can be authorized.

If you fail to follow these PAC/CSR requirements, penalties will apply. See the "OUT-OF-NETWORK HOSPITAL PRE-ADMISSION CERTIFICATION AND CONTINUED STAY REVIEW REQUIREMENTS" chart above.

Medical Emergencies and Urgent Care Coverage

If you are admitted to the **hospital** on an emergency basis for any reason, even for less than one day, you, a member of your family, the **physician** or the **hospital** must contact **Cigna Healthcare** within 48 hours of the admission. If you do not follow the admission certification requirements for emergency situations, penalties will apply. See the "OUT-OF-NETWORK HOSPITAL PRE-ADMISSION CERTIFICATION AND CONTINUED STAY REVIEW REQUIREMENTS" chart above.

Outpatient Prior Authorization and Certification Requirements

If your **physician** recommends that you receive outpatient diagnostic testing or other procedures as an outpatient in a **free-standing surgical facility**, **other health care facility** or a **physician's** office, the Plan may require prior authorization or certification. Examples of diagnostic testing and outpatient procedures are advanced radiological imaging, such as CT Scans, MRI, MRA or PET scans and hysterectomies.

Different processes apply depending on whether you receive care in-network or out-of-network.

Prior Authorization - For In-Network Care

Your network **physician** will obtain prior authorization for outpatient diagnostic testing and outpatient procedures performed at in-network **hospitals**, **free-standing surgical facilities** and other network facilities.

Certification Requirements – For Out-of-Network Care

You must follow a process – called "outpatient certification" to obtain certification of 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 an out-of-network **free-standing surgical facility**, **other health care facility** or a **physician's** office. You should call the Customer Service Center at 1.888.99Cigna (1.888.992.4462) to determine if outpatient certification is required before any outpatient diagnostic testing or procedures.

Outpatient certification should be only requested for non-emergency procedures or services. The request should be made at least four working days (Monday through Friday) before the test or procedure.

If you do not receive outpatient certification before any outpatient diagnostic testing or procedure is performed, the Plan will pay the **covered expenses** at only 50% and you will have to pay the other 50%. If the test or procedures is determined not to be **medically necessary**, but you go ahead with the test or procedure, the cost will not be covered by the Plan. The cost will not be a **covered expense**, and you will have to pay the entire cost.

The Plan will not treat any expenses for which the Plan denies or reduces payment because you fail to meet these out-of-network, outpatient certification requirements as expenses you have incurred for any other purpose under the Plan, except for the "Coordination of Benefits" section.

Diagnostic Testing and Outpatient Procedures

The outpatient diagnostic testing and procedures subject to prior authorization or certification include, but are not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans,
- Certain outpatient surgical procedures,
- Dialysis,
- Speech therapy,
- Diagnostic cardiology, and
- Radiation therapy.

If you are receiving out-of-network care, contact the Cigna Customer Service Center at 1.888.992.4462 for assistance.

Case Management

Case management is a voluntary service provided by **Cigna HealthCare** that can help you with treatment needs that extend beyond the acute care setting. The goal of case management is to ensure that you receive appropriate care in the most effective setting possible, whether at home, as an outpatient, or as an inpatient in a **hospital** or specialized facility. Under the case management program, a case management professional works closely with you, your family and the attending **physician** to determine appropriate treatment options which will best meet your 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 your family in times of medical crisis.

Case managers are registered **nurses** (RNs) and other credentialed health care professionals, who are 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. 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, your attending **physician** remains responsible for your actual medical care.

The case management process generally works as follows:

(1) You or an attending **physician** can request case management services by calling the Customer Service Center at 1.888.99.Cigna (1.888.992.4462) during normal business hours, Monday through Friday. In addition, **Cigna**, as your employer, a claim office or a PAC/CSR program may refer you for case management.

(2) The case management group assesses each case to determine whether case management is appropriate.

(3) An assigned case manager contacts you and explains in detail how the program works. Your participation in the program is voluntary – you will not be subject to any penalty or benefit reduction if you do not participate in case management.

(4) After an initial assessment, the case manager works with you, your family and **physician** to determine your needs 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 you do not follow the alternate treatment program.

(5) The case manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a **hospital** bed and other durable medical equipment for the home).

(6) The case manager also acts as a liaison between **Cigna HealthCare**, you, your family and **physician** as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).

(7) Once the alternate treatment program is in place, the case manager continues to manage the case to ensure the treatment program remains appropriate to your needs.

Participation in case management is strictly voluntary.

COORDINATION OF BENEFITS

This section applies if you or a **covered dependent** is enrolled in more than one group medical plan (for example, if your **spouse** has Cigna Medical Plan coverage as your **covered dependent** and is also covered by his or her current employer's plan). This section describes coordination of benefits (COB), the process for determining which plan is the "primary plan" that pays first and which plan is the "secondary" plan that pays only the remaining balance up to the total covered charges.

COB allows group medical plans to avoid duplication of benefits so that the total paid does not exceed the total covered amount for the services received.

Definitions for Coordination of Benefit Rules

The following terms apply to the COB section:

Group Medical Plan

A group medical plan either pays benefits or provides services for medical care or treatment and is one of the following:

- Group insurance and/or group-type coverage, whether insured or self-insured, which: (a) cannot be purchased by the general public, and (b) is not individually underwritten.
- Closed panel coverage that provides services through a panel of employed or contracted health care professionals and that limits or excludes services provided by health care professionals outside of the panel (except in the case of emergency or if referred by a health care professional within the panel).
- Coverage under Medicare and other governmental program as permitted by law, except Medicaid and Medicare supplement policies.
- Medical coverage under group, group-type, and individual automobile contracts.

Each group medical plan or part of a plan that has the right to coordinate benefits is considered a separate plan.

Allowable Expense

An allowable expense is a necessary, reasonable and customary service or expense for a service that is covered in full or in part by any group medical plan in which you are enrolled. When a group medical plan provides services, the reasonable cash value of each service is the allowable expense and considered the amount paid by the plan for the purposes of coordination of benefits.

Expenses or services that are not allowable expenses include, but are not limited to:

- An expense or service or a portion of an expense or service that is not covered by any of the group medical plans coordinating benefits.
- The difference in cost between a private and semiprivate room if you are hospitalized in a private hospital room and no group medical plan provides coverage for more than a semiprivate room.
- Any amount in excess of the highest reasonable and customary fee if you are covered by two or more group medical plans that provide services or supplies on the basis of reasonable and customary fees.
- If you are covered by one group medical plan that provides services or supplies on the basis of reasonable and customary fees and another group medical plan that provides services and supplies on the basis of negotiated fees, the allowable expense will be determined by the fee arrangement used by the plan that pays first.
- If the plan that pays first reduces your benefits because you did not comply with the plan provisions (including second surgical opinions and precertification of admissions or services) or because you did not use a preferred health care professional, the amount of the reduction is not an allowable expense.

Claim Determination Period

A calendar year, excluding any part of a year during which you are not covered under the Cigna Medical Plan.

Reasonable Cash Value

An amount which a licensed health care professional usually charges patients for a service if it is within the range of fees usually charged for the same service by **other health care professionals** who (1) are located in the immediate geographic area where the health care service is provided and (2) provide health care services under similar or comparable circumstances.

Order of Benefit Determination Rules

A group medical plan that does not have a COB rule consistent with this section is always the plan that pays first. If a group medical plan has a COB rule consistent with this section, the first of the following rules that applies determines which plan pays first and which plan pays second:

(1) The group medical plan that covers you as an employee or enrollee is the plan that pays before the group medical plan that covers you as a dependent.

(2) For a dependent child whose parents are not divorced or legally separated if both cover their dependent child under a group medical plan, the “birthday rule” applies. The plan covering the parent whose birthday falls earlier in the year pays first. Birthday refers to only the month and day in a calendar year, not the year in which someone was born. If both parents have the same birthday (month and day), the plan that has provided coverage longer pays first.

(3) If your child is covered by more than one group medical plan and you are divorced or separated from the other parent, the plans would pay in the following order:

(a) first, if a court decree states that one parent is responsible for the child’s health care expenses or health coverage, the group medical plan for that parent -- if the plan is notified of the terms of the order, but only from the time of notification;

(b) next, the group medical plan of the parent with custody of the child;

(c) next, the group medical plan of the **spouse**/**partner** of the parent with custody of the child;

(d) then, the group medical plan of the parent not having custody of the child, and

(e) finally, the group medical plan of the **spouse**/**partner** of the parent not having custody of the child.

(4) The group medical plan that covers you as an active employee (or as the dependent of an active employee) is the plan that pays first and the group medical plan that covers you as a former employee (or as the dependent of a former employee) is the plan that pays second. If the other group medical plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph does not apply.

(5) The group medical plan that covers you as an active employee or as a retiree (or as the dependent of an active employee or retiree) is the plan that pays first and the group medical plan that covers you under federal COBRA continuation or a state law requiring health care coverage continuation (see discussion of federal COBRA continuation rights under the heading of "COBRA Continuation Coverage") is the plan that pays second. If the other group medical plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph does not apply.

If none of these rules determines the order of benefits, the group medical plan that has covered you for the longer period of time is the plan that pays first.

Here are some examples of how these rules apply:

- If you (the **Cigna** employee) are the patient, but you also have coverage as a dependent under your **spouse**/**partner's** group medical plan, the Cigna Medical Plan (coverage option and accompanying account) will pay first and your **spouse** or **partner's** plan will pay next.
- If your **spouse**/**partner** is the patient and has coverage through his or her employer and under the Cigna Medical Plan as your **covered dependent**, your **spouse**/**partner's** plan will pay first and the Cigna Medical Plan will pay next.
- If your child is the patient, both you and your **spouse**/**partner** cover your child, you were born in January and your **spouse** was born in August, the Cigna Medical Plan will pay first (the plan of the parent whose birthday falls earlier in the year, regardless of the ages of the parents, is the plan that pays first). However, special coordination of benefits rules described above apply if you are divorced or legally separated from the child's other parent.

When the Cigna Medical Plan Pays Second

If the Cigna Medical Plan pays second, the amount you receive may be reduced, so that the total benefits paid by all group medical plans during a claim determination period are not more than 100% of the total of all allowable expenses.

The difference between the benefits that the Cigna Medical Plan would have paid if the Cigna Medical Plan had paid first, and the amount that the Cigna Medical Plan actually pays will be recorded as a benefit reserve for you.

The Plan will use this benefit reserve to pay any allowable expense not otherwise paid in full during the calendar year. As each claim is submitted the **claims administrator** will automatically determine whether there are any unpaid allowable expenses and use the benefits reserve recorded for you to pay up to 100% of this amount. At the end of the claim determination period, which is also the end of the calendar year in the case of the Cigna Medical Plan, any dollars remaining in the benefit reserve will be forfeited and not carried over to the subsequent calendar year.

Recovery of Excess Benefits

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for services or expenses that are not covered by the Plan, or for a participant who is not covered by the Plan, the Plan has the right to recover the overpayment. The Plan will have the right to recover an actual payment made or the reasonable cash value of any services provided if the Plan pays benefits that should have been paid first by another group medical plan or the Plan pays more than the covered amount under the Plan when the Plan pays first.

The **claims administrator** will have sole discretion to seek this recovery from any person to, or for whom, or with respect to whom, these services were provided or payments made by any insurance company, health care plan or other organization. The **claims administrator** will attempt to collect the overpayment from the party to whom the payment was made. However, the **claims administrator** reserves the right to seek overpayment from you and/or your **covered dependents**. Failure to comply with a request to repay an overpayment will entitle the Plan to withhold benefits due you and/or your **covered dependents**.

The **claims administrator** has the right to refer a claim for overpayment to an outside collection agency. It may also bring a lawsuit to enforce its rights to recover overpayments.

If requested, you must provide any requested information as determined necessary by the **claims administrator** to secure the right of recovery.

Right to Receive and Release Information

The **claims administrator**, without consent or notice to you, may obtain information from and release information to any other group medical plan relating to you in order to coordinate your benefits under this section.

You must provide any requested information in order to coordinate your benefits. When a request for information relates to a submitted claim, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid by the other medical plan) is required before the **claims administrator** will process the claim. If you do not respond within 90 days of this request, the claim will be denied. The **claims administrator** will automatically reopen and process your claim provided the requested information is received by the end of the 90-day period.

Medicare Eligibles

If you or your **covered dependent(s)** are enrolled in Medicare while you are actively employed, participation in this Plan will continue as long as you are an active employee and remain enrolled. In that circumstance, this Plan will pay primary and Medicare will pay secondary.

Medicare will pay primary and this Plan will pay secondary in the following situations:

- If you or a **covered dependent** is eligible for Medicare and Cigna Medical Plan coverage is continued under COBRA for any reason, as provided in this Plan; or
- If you or any **covered dependents** are eligible for Medicare due to End Stage Renal Disease, once you or any **covered dependents** have been eligible for Medicare for 30 months, to the extent permitted by applicable law.

If you are on a leave of absence or you are receiving disability benefits, the following Medicare Secondary Payor coordination rules apply:

- Leave of Absence/No Disability: If you take a leave of absence, retain coverage under the Plan, and are not receiving disability benefits from **Cigna**, the Plan will continue to pay primary for as long as you retain your right to return to active employment, (i.e., your employment is not terminated by **Cigna**), provided that you are not receiving disability benefits from the Social Security Administration. If your employment is terminated by **Cigna** and/or if you begin to receive benefits from the Social Security Administration (and the subsequent paragraph below does not apply), Medicare will become primary for you and/or any **covered dependents**.
- Leave of Absence/Disability: If you take a medical leave of absence, retain coverage under the Plan, and start receiving disability benefits from **Cigna**, the Plan will continue to pay primary for the first 6 months of your disability coverage (i.e., while disability benefits are subject to FICA tax). After this 6-month period, Medicare will become primary for you and/or any **covered dependents**.

If you are receiving benefits under the Cigna Long-Term Disability Plan, your coverage will be transferred to the Cigna Medical Plan for Retirees, Survivors and Disabled Employees on January 1 following the date you first receive long-term disability benefits from **Cigna**. Coverage for your **covered dependents** will also be transferred to the Cigna Medical Plan for Retirees, Survivors and Disabled Employees.

The **claims administrator** will assume a Medicare payment was made as if a person has applied or enrolled as follows under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, regardless of whether the person has applied.
- Part B of Medicare for a person who is eligible to enroll in that Part, regardless of whether the person has enrolled.
- Part B of Medicare for a person who has entered into a private contract with a health care professional, to be the amount he would receive in the absence of such private contract.

A person is considered entitled to Medicare payments on the earliest date any coverage under Medicare could become effective for him/her. If Medicare would be the primary payer, the Plan will not pay expenses that would otherwise be covered by Medicare. Timely enrollment in Medicare Parts A and B will ensure proper coordination of benefits. You may obtain further information on Medicare eligibility by contacting Medicare directly at 1.800.MEDICARE or www.Medicare.gov.

However, when more than one Plan is secondary to Medicare, the rules in the "Order of Benefits Determination Rules" section will be used to determine how benefits will be paid.

Prescription Drug Benefits

The Plan includes coverage for prescription drug benefits. However, if you are a Medicare-eligible individual, you are also entitled to enroll in a prescription drug plan under Medicare Part D. If you decide to join a Medicare drug plan as a supplement to the prescription drug coverage you receive under the Cigna Medical Plan, your enrollment in the Medicare drug plan will not reduce your prescription drug benefits under the Cigna Medical Plan. However, your benefits under the Medicare drug plan may be affected by your prescription drug coverage under the Cigna Medical Plan. You are therefore urged to consider the options carefully prior to making a Medicare Part D election.

If you decide to join a Medicare drug plan and drop your current Cigna Medical Plan coverage, you can elect this coverage again during open enrollment or upon the occurrence of a change in election event.

Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to **partners** covered under a group health plan. Therefore, Medicare always pays first for a person covered as a **partner**, and the Plan pays after Medicare.

Coordination for Overseas Business Travel Coverage

If you are traveling on Cigna business outside the U.S. and are covered under another Cigna-sponsored plan that provides medical benefits for Cigna employees traveling abroad on business, that plan will be considered the primary plan that pays first. Your Cigna Medical Plan will coordinate coverage with, and will pay after, that plan.

WHEN A THIRD PARTY MAY BE RESPONSIBLE FOR BENEFITS

This section describes the Plan's rights to be repaid if you receive Plan benefits after an injury, illness or other condition and then recover from someone else (a third party) money in payment for your related medical expenses. That money must be repaid to the Plan. As is true in most other parts of the SPD, "you" as used here includes your **covered dependents**.

The Plan does NOT cover:

(1) Expenses you incur if another party may be responsible for those expenses because he or she caused or contributed to your injury, illness or other condition.

(2) Expenses you incur to the extent you receive any payments for them (either directly or indirectly) from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any of the following or a similar type of coverage: compromises or awards, medical payment coverage (auto, homeowners

or otherwise), any no-fault insurance, uninsured or underinsured motorist insurance, workers' compensation settlement, government insurance (other than Medicaid), and other group insurance (including student plans).

Subrogation/Right of Reimbursement

If you incur a **covered expense** and the Plan or its **claims administrator** determines that another party may be responsible for the expenses or you may receive payment as described above:

(1) Subrogation: The Plan shall, to the fullest extent permitted by law in the appropriate jurisdiction, be subrogated to all rights, claims, demands or interests that you may have against the responsible party. Such party may include (1) any other person (including, but not limited to, his or her insurance companies and carriers), whose action or inaction caused or contributed to the injury, illness or other condition for which Plan benefits are paid; and (2) any other third party, including, but not limited to, your automobile or other insurance company or carrier. The amount of subrogation will equal the total amount paid under the Plan arising out of the injury, illness or other condition together with any attorneys' fees and costs that the Plan incurs in enforcing its subrogation rights under these subrogation and right to reimbursement provisions. The Plan is not required to participate in or pay attorneys' fees, costs, or expenses to any attorney hired by you (or your guardian, estate, heir, or other representative) in pursuit of claims against a person who caused or contributed to the injury, illness or other condition; however, the Plan may bring an action on its own behalf or your behalf against any responsible party or third party involved in the injury, illness or other condition.

The Plan may advance monies or provide benefits for an injury, illness or other condition for which another party is responsible, and, if so, the Plan is subrogated to all of your rights against any party liable for your injury, illness or other condition, or who is or may be liable for the payment for the medical treatment of such injury, illness or other condition in the amount of monies or value of other benefits advanced or provided by the Plan to you. The Plan may assert this right independently of you. The Plan is not obligated in any way to pursue this right independently or on your behalf, but may choose to pursue its rights to reimbursement under the Plan, in its sole discretion.

You are obligated to cooperate with the Plan and its agents to protect the Plan's subrogation rights. Your obligations include, but are not limited to, providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to enforce the Plan's subrogation rights, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If you enter into litigation or settlement negotiations relating to your injury, illness or other condition, you must not prejudice, in any way, the subrogation rights of the Plan. If you fail to cooperate as provided, including executing any required documents, the Plan may, in addition to remedies provided elsewhere in the SPD and/or under the law, set off from any future benefits otherwise payable under the Plan the money and value of other benefits advanced to the extent not recovered by the Plan.

The Plan will automatically have a lien on the proceeds of any recovery by you from that third party to the extent of any benefits paid under the Plan.

(2) Right of Reimbursement: The Plan is also granted a right to be reimbursed from the proceeds of any recovery you (or your attorney, guardian, heir, estate, or other representative) receive from any sources related to such injury, illness or condition (including, but not limited to: (1) any policy or contract from any insurance company or carrier (including your automobile or other insurer); and/or (2) any third party, plan, or fund as a result of a judgment, arbitration award, verdict, insurance payment, settlement or other recovery, regardless of whether or not (1) you have been fully compensated, or made whole for your loss, (2) liability is admitted by you or any other party, or (3) the recovery by you is itemized or specified as a recovery for medical expenses incurred).

If a recovery is made, the Plan shall have first priority in payment over you or any other party to receive reimbursement of the monies and value of the other benefits advanced on your behalf. This reimbursement shall be from any recovery made by you, and includes, but is not limited to, uninsured and underinsured motorist

coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties. The Plan has a right to be reimbursed from such payment for all amounts the Plan has paid or will pay as a result of that illness, injury or other condition. This right of reimbursement is cumulative with, and not exclusive of, the Plan's subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan.

Lien of the Plan

By accepting any benefits advanced under this Plan, you:

- Acknowledge that if the Plan advances monies or provides benefits for an injury, illness or other condition, and you recover monies or benefits from a third party due to that particular injury, illness or condition (of any sum up to the amount of the monies or benefits advanced), the Plan has an equitable lien in connection with such payments. This lien is binding on any attorney or other party who represents you, whether or not that attorney is your agent or the agent of any insurance company or other financially responsible party against whom you may have a claim if the attorney, insurance carrier or other party has been notified by the Plan or its agents;
- Acknowledge that any proceeds of settlement or judgment, including your claim to such proceeds held by another person, held by you, or by another, are being held for the benefit of the Plan;
- Agree that this lien shall constitute a charge against the proceeds of any recovery and the Plan shall be entitled to assert a security interest thereon; and
- Agree to hold the proceeds of any recovery in trust for the benefit of the Plan to the extent of any payment made by the Plan. Failure to hold such received funds in trust, and in a separate, identifiable account, will be deemed a breach of your obligation to the Plan.

Additional Terms

- The above subrogation and reimbursement rights arise immediately upon payment of any benefits under the Plan.
- You (and your guardian, estate, heir or other representative) shall cooperate fully with the Plan and **Cigna** in asserting and protecting the Plan's subrogation and reimbursement rights.
- When requested by the Plan, the **claims administrator** or their designees, you (or your guardian, estate, heir or other representative) specifically agree to notify **Cigna** in writing if benefits are paid under the Plan for care arising out of any injury or illness that provides or may provide the Plan subrogation or reimbursement rights pursuant to the above subrogation and right to reimbursement provisions.
- When requested by the Plan, the **claims administrator** or their designees, you (or your guardian, estate, heir or other representative) specifically agree to notify the Plan in writing of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- You and your adult **covered dependents** may not assign any rights to recover medical expenses from any third party or other person or entity to any minor dependent without the prior express written consent of the Plan. The Plan's right to recover shall apply to the settlements or recoveries of decedents, minors, and incompetent or disabled persons.
- You (and your guardian, estate, heir or other representative) shall not to do anything to prejudice the Plan's right to reimbursement or subrogation, including making any settlement which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.
- The Plan's right of recovery shall be a prior lien against any proceeds you recover and this right shall not be defeated or reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such equitable doctrine or state law purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- You must assign to the Plan any benefits you may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. You shall sign and deliver, at the request of the Plan or its agents, any documents needed to effect such assignment of benefits.
- You shall not incur any expenses on behalf of the Plan in pursuit of the Plan's rights. Specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," "Attorney's Fund Doctrine," or other equitable or legal defenses.
- The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on your part, whether under comparative negligence or otherwise.
- If you fail or refuse to honor your obligations, then the Plan will be entitled to recover any costs incurred in enforcing these terms. These costs may include, but are not limited to, attorney's fees, litigation, court costs, and other expenses. The Plan is also entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until you have fully complied with your reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

By accepting benefits under the Plan, you agree that a breach would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Cigna, in its sole and absolute discretion, may waive or modify any or all of the above provisions.

CLAIMS AND BENEFIT PAYMENTS

How to File Your Claims

In-Network and Out-of-Network Services in General

You do not have to file claim forms if you use network health care professionals or facilities, participating **pharmacies** or the Cigna Home Delivery Pharmacy, but you must pay any applicable **deductible** or **coinsurance** amount.

You must file claims to receive payment for out-of-network services, including having prescriptions filled at non-participating **pharmacies**. You may have to pay when you receive services and then submit a claim for reimbursement. Claim forms for most types of services are available online on the *Your Cigna Life* website (click on *Self Service>Employee Self Service>Forms/Tools & Resources*). In addition to the instructions on the claim form, below is information about filing claims for particular types of services:

Hospital Stays: If you use an out-of-network **hospital**, if possible, get your claim form before you are admitted to the **hospital**. This form will make your admission easier and any cash deposit usually required will be waived.

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

Filing Deadline: Unless otherwise specified in the description of applicable benefits, you or your **covered dependent(s)** must file an initial claim for out-of-network group health care program benefits within 180 days of the date of service (24 months if coordinating with another plan.) You or your **covered dependent(s)** must complete the required claims and appeals process described in this "Claims and Benefit Payments" section and in the "Appeals Process" section before you may bring legal action or, where applicable, pursue external review. You may not file a lawsuit for benefits if the initial claim or appeal is not made within the time periods described in the "Claims and Benefit Payments" and "Appeals Process" sections.

Claim Reminders

- Be sure to use your medical ID number and account number when you file your claims.
- Your medical ID number is shown on your medical ID card.
- Claim forms include the 7-digit policy number, which is also shown on your medical ID card.
- Prompt filing of any required claim forms will result in faster payment of your claims.

Payment of Benefits

The Plan generally makes payments directly to network health care professionals or facilities that provide your **covered services**. By using network services, you are automatically authorizing **Cigna HealthCare**, and any network health care professionals and facilities to release your relevant medical records to the **claims administrator** to determine applicable benefits or reimbursements for the services you receive.

Plan benefits are not assignable unless agreed to by the **claims administrator**. The **claims administrator** may, at its option, make payment to you for the cost of any **covered services** received by you or your **covered dependent** out-of-network, even if benefits have been assigned. When benefits are paid to you, you are responsible for reimbursing the health care professional or facility. If the person to receive the payment is a minor or, in the **claims administrator's** opinion, cannot give a valid receipt for the payment, the Plan will pay that person's legal guardian. If no legal guardian requests payment, the Plan may, at its option pay the person or institution that appears to have responsibility for the person's custody and support.

If you die while any Plan benefits remain unpaid, the Plan may pay any of your following living relatives: **spouse** or **partner**, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

The Plan will not be liable for any additional payments to the extent it makes a payment to a living relative or other person listed above.

Recovery of Overpayments

If the Plan makes an overpayment, the Plan or its designee has the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

CLAIM DETERMINATION PROCEDURES

Medical Necessity Determinations

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 – **medical necessity** determinations are made on either a preservice, concurrent, or postservice basis.

Certain services require prior authorization in order to be covered under the Plan as described above. This SPD describes who must ask for this authorization.

You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described elsewhere, in this SPD and in your health care professional'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 you may appeal the determination. Appeal procedures are described in this SPD, in your health professional's network participation documents, and in the determination notices.

Preservice Determinations

When you or your representative request a required prior authorization, the **claims administrator** will notify you or your representative of the determination within 15 days after receiving the request. However, if the **claims administrator** needs more time due to matters beyond its control, the **claims administrator** will notify you or your representative within 15 days after receiving your request. This notice will include the date you can expect a determination, 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. You or your representative must provide the specified information to the **claims administrator** within 45 days after receiving the notice. The determination period will be suspended on the date the **claims administrator** sends the notice of missing information, and will resume on the date you or your representative responds to the notice.

If the determination periods above would (a) seriously jeopardize your life or health or your ability to regain maximum function, or (b) in the opinion of a **physician** with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, the **claims administrator** will make the preservice determination on an expedited basis. The **claims administrator's** Physician Reviewer will defer to the determination of the treating **physician** regarding whether an expedited determination is necessary. The **claims administrator** 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, the **claims administrator** 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 the **claims administrator** within 48 hours after receiving the notice. The **claims administrator** 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 the **claims administrator's** procedures for requesting a required preservice determination, the **claims administrator** 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. The **claims administrator** may provide this notice orally, unless you or your representative asks for 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 before the previously approved period of time expires or the number of treatments is reached. The **claims administrator** will notify you or your representative of the determination within 24 hours after receiving that request.

Postservice Determinations

When you or your representative requests a coverage determination after services have been rendered, the **claims administrator** will notify you or your representative of the determination within 30 days after receiving the request. However, if **the claims administrator** needs more time to make a determination due to matters beyond its control the **claims administrator** will notify you or your representative within 30 days after receiving the request. This notice will include the date you can expect a determination, which will be no more than 45 days after receipt of the request.

If the **claims administrator** needs more time because necessary information is missing from the request, the notice will also specify what information is needed. You or your representative must provide the specified information to the **claims administrator** within 45 days after receiving the notice. The determination period will be suspended on the date the **claims administrator** 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 relate to the determination:

- Enough information for you to identify the claim;
- The specific reason or reasons for 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 your rights to bring a civil action under section 502(a) of **ERISA** following an adverse benefit determination on appeal;
- Upon your request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in denying your claim;
- 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
- In the case of a claim involving **urgent care**, a description of the expedited review process applicable to such claim.

APPEALS PROCESS

The Cigna Medical Plan has two different appeal procedures. One is for eligibility/election issues; the other is for coverage/benefit issues.

An "eligibility/election" issue is one that deals with:

- Your eligibility to enroll in a Cigna Medical Plan option;
- The eligibility of your dependents;
- Your enrollment;
- Your coverage elections;
- Your dependent elections;
- Your cost for coverage (your **payroll cost**); or
- Changes in your elections – including **life status changes**.

A "coverage/benefit" issue is one that deals with:

- Whether the option you elected covers a particular illness, injury, treatment or procedure; or
- If there is coverage, the level of benefit the option provides and the level of benefit to which you might be entitled.

The appeals process for each of eligibility/election issues and for coverage/benefit issues is described in the next section.

You may treat any issue that does not clearly fall into one of the above categories as an eligibility/election issue.

Eligibility/Election Issues

Level One Appeal

If you have a problem with or disagree with a decision about an eligibility/election issue, you may file an appeal by using the process described in this section. As part of the process, you are entitled to review pertinent documents and have a qualified person represent you in the review.

You may start the appeal process by writing about your problem to the Your Cigna Life Service Center at:

Post Office Box 62825
Phoenix, AZ 85082

You must make your written appeal within 180 days after the event that gives rise to your problem. Your appeal letter should include (1) your name, (2) the plan name, (3) an explanation of why you believe your claim is valid and (4) copies of any supporting documents. Someone other than you may write an appeal letter on your behalf if you have clearly authorized that person in writing to represent you and a copy of that written authorization, signed by you, is included with the appeal letter.

The Your Cigna Life Service Center will normally make a decision on your appeal within 30 days after receipt of your appeal letter. However, if special circumstances require more time to make a decision, the Your Cigna Life Service Center may need an extension of up to 15 more days to consider your appeal. The Your Cigna Life Service Center will notify you in writing prior to the end of the 30-day period of any extension and the reason for it and if additional information is required.

If you must provide additional information to support your appeal:

- The notice of the extension will detail the information you need to provide;
- You will have at least 45 days to provide the information; and
- The running of the 15-day extension period will be suspended until the Your Cigna Life Service Center receives the additional information.

The Your Cigna Life Service Center will notify you in writing of the decision on your appeal. If your appeal is denied in whole or in part, the notice will include:

- The specific reason for the denial;
- References to Plan provisions on which the denial is based;
- A statement that you may request access to or copies, free of charge, of all documents, records and other information relevant to your claim; and
- A description of the Plan's procedures for appealing the decision and a statement of your rights to bring a civil action under **ERISA**.

If you have not received a decision by the end of the 30-day period (or the end of the extended period, if you received notice about the extension), you may treat your appeal as denied.

Filing a Final Appeal

If your appeal to the Your Cigna Life Service Center is denied in whole or in part, and you disagree with the decision, you may make a final appeal to the **plan administrator**. Your final appeal must also be in writing and must be sent within 180 days from the date that you receive written notice of the denial of your level one appeal from the Your Cigna Life Service Center. You should address your final appeal letter to:

Office of the Plan Administrator
Cigna Corporation
Two Liberty Place, TL05T
1601 Chestnut Street
Philadelphia, PA 19192

Your final appeal letter should contain an explanation of why you think your request should be approved and copies of any supporting documents. Someone other than you may write an appeal letter on your behalf if you have clearly authorized that person in writing to represent you and a copy of that written authorization, signed by you, is included with the appeal letter.

In considering your appeal, the **plan administrator** will review your written appeal letter, any relevant documents you provide, the relevant Plan provisions and other relevant information. The **plan administrator** will normally make a decision on your appeal within 30 days after receiving your appeal letter.

The **plan administrator** will notify you in writing of the decision on your final appeal, and that decision is final. If your appeal is denied, this written notice will include:

- The specific reason for the denial;
- References to Plan provisions on which the denial is based;
- A statement that you may request access to or copies, free of charge, of all documents, records and other information relevant to your claim; and
- A statement of your right to bring a civil action for Plan benefits under **ERISA** section 502(a).

If you have not received a decision by the end of the 30-day period, you may treat your appeal as denied.

The **plan administrator** has the sole discretion to determine any eligibility/election issues; to interpret any of the Plan's provisions relevant to eligibility/election issues (and issues, if any, that are neither eligibility/election issues; nor coverage/benefit issues), including any ambiguous or disputed terms; and to make any related factual determinations. The **plan administrator's** determinations and interpretations are final and binding on all parties.

Coverage/Benefit Issues

If you have a problem with or disagree with a decision about a coverage/benefit issue, you may file an appeal by using the process described in this section. In this section, the terms "you" and "your," depending on the context, may also refer to your authorized representative.

NOTE: Health care providers are not "beneficiaries" of the plan, and although Cigna may make direct payment to health care providers for the convenience of participants and their dependents, such payments for services shall not be considered "benefits" available under the plan, or confer beneficiary standing upon a health care provider.

Physician Reviewers are licensed **physicians** who specialize in areas appropriate for the care, service or treatment under review.

Start With the Customer Service Center

If you have a concern about a person, a service, the quality of care, Plan benefits, or a rescission of coverage, you may call the Customer Service Center -- at 1.888.99Cigna (1.888.992.4462) -- to explain your concern to a Customer Service representative. You may also express your concern in writing.

The Customer Service representative will try to resolve the matter on your initial contact. If the Customer Service Center needs more time to review or investigate your concern, a representative will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage or benefits decision, you may start the appeals procedure.

Internal Appeals Procedure

To start an appeal, you must submit a written request for an appeal to the **claims administrator** within 180 days after you receive a denial notice. Address the appeal to:

Cigna HealthCare
ICARE Appeals
P.O. Box 188011
Chattanooga, TN 37422

Your appeal letter should explain why you think your appeal should be approved and include any information that supports your appeal. If you cannot or choose not to write, you may start your appeal by telephone. Call the **claims administrator** at 1.888.992.4462 for assistance.

Appeals Procedure

Your appeal will be reviewed and decided by someone not involved in the initial decision. A health care professional will consider appeals involving **medical necessity** or clinical appropriateness.

The **claims administrator** will respond in writing with a decision on your appeal:

- within 30 calendar days after receiving an appeal for a required preservice or concurrent care coverage determination or a post-service **medical necessity** determination, and
- within 60 calendar days after receiving an appeal for any other postservice coverage determination.

If the **claims administrator** needs more time or information to make the determination, the **claims administrator** will notify you in writing to request an extension of up to 15 more calendar days and will specify any additional information it needs to complete the review.

In the event any new or additional information (evidence) is considered, relied on or generated by the **claims administrator** in connection with the appeal, the **claims administrator** 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 the **claims administrator**, the **claims administrator** 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 ask the **claims administrator** for a quicker decision (an expedited appeal) if:

(a) the above timing would seriously jeopardize your life, health or ability to regain maximum functionality or in your **physician's** opinion would cause you severe pain which cannot be managed without the requested services; or

(b) your appeal involves non-authorization of a **hospital** admission or continuing inpatient **hospital** stay.

If you ask for an expedited appeal based on (a) above, you may also ask for an expedited external independent review (see "Independent Review Process") at the same time, if the time to complete an expedited appeal would be detrimental to your medical condition.

When an appeal is expedited, the **claims administrator** will respond orally with a decision within 72 hours, with a written follow up.

External Review Process

If you are not satisfied with the **claims administrator's** decision on your internal appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by the **claims administrator**, Cigna HealthCare, or any of its affiliates. A decision to use the voluntary level of appeal will not affect your rights to any other Plan benefits.

There is no charge for you to initiate the independent review process. The **claims administrator** will accept the decision of the IRO.

To request an independent review, you or an authorized designated representative, must notify the Appeals Coordinator within 4 months after you receive notice that the **claims administrator** has denied your appeal. The **claims administrator** will then forward the claim file to a randomly selected IRO. The IRO will render an opinion within 45 days.

You can ask for an expedited review process if a delay would be detrimental to your medical condition, as determined by the **claims administrator's** Physician Reviewer, or if your appeal involves an admission, availability of care, continued stay, or health care item or service for which you received **emergency services**, and you have not yet been discharged from a facility. If your request is granted, the review will 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. If the decision involves a denial of your claim, the notice will include:

- Enough information to identify the claim;
- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information as defined below;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to bring an action under **ERISA** section 502(a);
- Upon your request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in denying your claim; and
- An explanation of the scientific or clinical judgment for any determination that is based on a **medical necessity**, experimental treatment or other similar exclusion or limit.

A final notice of claim denial will include a discussion of the decision.

Relevant Information

Relevant information is any document, record or other information that:

- Was relied on in making the benefit determination;
- Was submitted, considered or generated in the course of making the benefit determination, even if the document, record, or other information was not actually relied on 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 under the Plan about the denied treatment option or benefit for the applicable diagnosis, even if the advice or statement was not actually relied on in making the benefit determination.

Legal Action

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 begin a legal action until you have completed the appeal processes. You must file any lawsuit for benefits within one year after the final decision on appeal. You may not file suit after the one-year period expires. You or your **covered dependent(s)** are not required to request voluntary internal review or an external review before filing a lawsuit. If you or your **covered dependent(s)** do request voluntary internal review or an

external review of the decision, the time taken to appeal under the voluntary review process will not be counted against the one year in which you have to file a lawsuit.

Voluntary Review of Your Coverage Appeal Decision

If you have exhausted the appeals process described above and you believe there has been an error or that your appeal has not been handled properly, you may make a voluntary request that the **plan administrator** review your claim.

You do not have to ask for this voluntary review, and whether you ask or not will have no effect on your right to: any other Plan benefits, to pursue any legal remedies you have, to information about applicable Plan rules or to be represented by someone during your appeal. If you do not ask for a **plan administrator** review, the Plan will not assert any claim that you failed to exhaust the appeal process, for failing to request such review. If you do ask for a **plan administrator** review, the Plan agrees that any statute of limitation or lack of timeliness defenses it may have are suspended while the review is pending.

If you want the **plan administrator** to review your claim, send a written request addressed to:

Office of the Plan Administrator
Cigna Corporation
Two Liberty Place, TL05T
1601 Chestnut Street
Philadelphia, PA 19192

You must mail your request within 60 days after you receive notice of the denial of your appeal or, if you request independent review, 60 days after that denial. You must explain in your request letter why you think the decision of your appeal is wrong.

The **plan administrator** will investigate the decision on your appeal and determine whether all the appeal procedures were followed in reaching a decision and whether the decision was consistent with the terms of the Plan. The **plan administrator** will notify you of the results of the review within 30 days after receiving your request for review. If the Plan Administrator needs more time (but not more than 60 days), the **plan administrator** will notify you about the extension and the reason for it.

COBRA

This section of the SPD contains important information about your right to COBRA continuation coverage (or COBRA coverage), which is a temporary extension of Plan coverage on a self-pay basis. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This section explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

Your rights to COBRA coverage may change as further amendments to COBRA are made by Congress or as interpretations of COBRA are made by the courts and by federal regulatory agencies.

COBRA Continuation Coverage

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a qualifying event. Specific qualifying events are listed in the next section. COBRA coverage must be offered to each person who is a qualified beneficiary. A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, **spouses** of employees, and dependent children of employees may be qualified beneficiaries. You are a qualified beneficiary under COBRA if you were a covered employee or a **covered dependent** of a covered employee on the day before the occurrence of a qualifying event. A child is a qualified beneficiary if he or she is born to the covered employee, while the covered employee is covered under COBRA. Qualified beneficiaries have the same rights as active employees.

Under the Plan, qualified beneficiaries who elect COBRA coverage must pay the full cost of the coverage (employer and employee share) plus an administrative fee. In most instances the cost is the full group rate plus a 2% administration fee. However, **Cigna** subsidizes some of the cost for COBRA coverage in these two situations:

- While you are receiving biweekly severance payments, **Cigna** subsidizes 65% of the cost at the group rate for Cigna Medical Plan COBRA coverage. You or your qualified beneficiaries will be charged only 35% of the cost.
- If you die while a **regular employee**, **Cigna** subsidizes Cigna Medical Plan COBRA coverage during the entire COBRA period, so that your qualified beneficiaries will be charged only the employee share of the group rate.

If the cost of active coverage changes after your COBRA coverage starts, the cost of your COBRA coverage also changes. You must send your first COBRA payment to the address listed on your COBRA election notice postmarked no more than 45 days after the date that you elect COBRA coverage. **You must make the rest of your monthly payments in full postmarked no more than 30 days after the date they are due or your COBRA coverage could terminate retroactive to the last date for which premiums were paid.**

For more information about COBRA rates, contact the Plan's COBRA Administrator.

Adding Dependents

Only children born to you or adopted by you during your COBRA coverage may be added as **covered dependents**. If you do not choose COBRA coverage and did not pay for COBRA coverage within the time limits set by COBRA, you may not be eligible for COBRA coverage in the future for the same qualifying event.

Removing Dependents

You do not have to elect full family coverage; you can elect coverage for yourself and/or any **eligible dependents**.

Partners

Your **partner** and his or her dependent children do not have rights to COBRA coverage under existing federal law, but **Cigna** offers them the same right to continued coverage (described below) that an employee's **spouse** and the **spouse's eligible dependent** children have.

Qualifying Events

You are eligible for COBRA coverage only if a qualifying event occurs that results in the loss of active coverage for you or for your **covered dependents**. If you are an employee, you become a qualified beneficiary if you lose your Plan coverage because of either one of these qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

Your covered **spouse** becomes a qualified beneficiary if you lose your Plan coverage because of any of these qualifying events:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become enrolled in Medicare (Part A, Part B or both);
- You become divorced or legally separated from your **spouse**; or
- Your marriage is annulled.

Your **covered dependent** child becomes a qualified beneficiary if he or she loses Plan coverage because of any of these qualifying events:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become enrolled in Medicare (Part A, Part B, or both);
- You become divorced or legally separated; or
- The child stops being an **eligible dependent**.

Notices About Qualifying Events

The Plan offers COBRA coverage to qualified beneficiaries only after the Your Cigna Life Service Center has been notified that a qualifying event has occurred.

Your employer notifies the **plan administrator** or Your Cigna Life Service Center if the qualifying event is the termination of your employment; reduction of your hours of employment; or your death. The employer must provide notice of the qualifying event within 30 days of the event.

You must notify the Your Cigna Life Service Center about any other qualifying events (your divorce or legal separation or when a child stops being an **eligible dependent**). To qualify for COBRA continuation, you must provide the notice within 60 days after the later of the qualifying event or when you would lose coverage as a result of the qualifying event.

If you do not record these qualifying events within the appropriate 60-day period, COBRA coverage will not be available.

You may provide this notice by going to the Life Events section of the *Your Cigna Life* website (Self Service>*Employee Self Service >Life Events*) if the notice is within 30 days after the qualifying event. You may also send your notice of a qualifying event to the Your Cigna Life Service Center by fax to 855.674.5282, by email to YCLServiceCenter@Cigna.com or by mailing a hard copy to the following address:

Post Office Box 62825
Phoenix, AZ 85082

Electing COBRA

Once the Your Cigna Life Service Center receives notice that a qualifying event has occurred, COBRA coverage is offered to each qualified beneficiary, who has a right to elect COBRA coverage independently of other qualified beneficiaries. The Plan's COBRA Administrator will issue a COBRA election notice, which will list the individuals who are eligible for COBRA coverage and inform you of the applicable premium. As an employee, you may elect COBRA coverage on behalf of your **spouse**, and you or your **spouse** may elect COBRA coverage on behalf of your children. You must notify the Plan's COBRA Administrator of your election no later than the due date stated on the COBRA election notice by following the procedures specified on the election form.

COBRA Premiums

If you elect continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. If you do not make your first payment in full by that date, you will lose your right to COBRA coverage under the Plan.

After you make your first payment for COBRA coverage, you must then make subsequent payments each month of the required premium for each additional month of coverage. More details on the required premium amount and payment deadlines will be provided in your COBRA election notice.

The COBRA Period

COBRA coverage is a temporary continuation of coverage. If it is elected, COBRA coverage begins on the date that Plan coverage would otherwise have been lost.

The maximum COBRA Period is 36 months if the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, the dissolution of your **partnership**, or when a **covered dependent** child stops being an **eligible dependent**.

The maximum COBRA period is 18 months if the qualifying event is the termination of your employment with **Cigna** for reasons other than gross misconduct, as defined by **Cigna** or the reduction of your work hours. However, if you become entitled to (enroll in) Medicare less than 18 months before your termination or reduction in hours, the maximum COBRA period for your qualified beneficiaries ends 36 months after the date you became entitled to Medicare. For example, if you become entitled to Medicare 8 months before your employment terminates, COBRA coverage for your **spouse** and children can last up to 36 months after the date of Medicare entitlement, or 28 months after your termination date.

Extension of the 18-Month COBRA Period

There are several ways in which the 18-month COBRA period described above can be extended. In all of these cases, you must notify the Plan's COBRA Administrator about the second qualifying event within 60 days after it happens. Send the notice to:

CONEXIS

P.O. Box 223684

Dallas, TX 75222-3684

Include with the notice copies of documents that prove the second qualifying event actually happened.

Disability Extension

If the Social Security Administration determines that you or one of your qualified beneficiaries is disabled before the qualifying event or at any time during the first 60 days of COBRA coverage and you notify the Plan's COBRA Administrator in a timely fashion as described in the preceding paragraph, you and each of your qualified beneficiaries who has elected continuation coverage can receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months.

The disability must start before the 60th day of your initial COBRA period and last at least until the end of the initial 18-month COBRA period. If you or the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan's COBRA Administrator of that fact within 30 days after the determination.

The Plan provides the longer period of COBRA coverage only if the Social Security Administration sends you a notice confirming your disability before the end of the 18th month of your COBRA coverage and confirms the disability onset was no later than the 61st day of COBRA coverage. The notification from the Social Security Administration must be sent to the Plan's COBRA Administrator no more than 60 days after the latest of any one of the following events:

- The date of the notice from the Social Security Administration;
- The date of the qualifying event;
- The date that benefits are terminated; or
- The date on which the qualified beneficiary is informed, through the Plan's SPD or the general COBRA notice, of his or her obligation to provide notice, and the procedures for providing such notice.

Second Qualifying Event Extension

If your family experiences another qualifying event during the initial 18-month period of COBRA coverage, your **spouse** and **covered dependent** children can receive up to 18 additional months of COBRA coverage (for a maximum of 36 months after the initial qualifying event). This extension is available to:

- Your **spouse** and **covered dependent** children if you die, enroll in Medicare (Part A, Part B, or both), get divorced or legally separated, have a dissolution of your **partnership**, or your employment with **Cigna** ends for any reason; and

- Your child if he or she stops qualifying as an **eligible dependent**.

The extended COBRA period is available only if the new qualifying event would have caused your **spouse** or child to lose coverage under the Plan if the first event had not occurred.

Terminating COBRA Coverage Before the End of the Maximum COBRA Period

COBRA coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full on time or within the grace period required by COBRA;
- A qualified beneficiary begins coverage under another group health plan after electing COBRA coverage (as long as that plan doesn't impose an exclusion or limitation with respect to a preexisting condition of the qualified beneficiary-if there is such an exclusion or limitation, COBRA coverage does not end for this reason until the exclusion or limitation no longer applies);
- A qualified beneficiary enrolls in Medicare (Part A, Part B, or both) after electing continuation coverage;
- **Cigna** ceases to offer the plan in which you are enrolled. However, COBRA coverage may be available under other **Cigna** plans. If all **Cigna** plans are terminated, all COBRA coverage is also terminated; or
- A qualified beneficiary engages in conduct that would justify the Plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

When COBRA Coverage Ends Generally

COBRA coverage ends on the date any one of the following events occur, whichever comes first:

- The date the maximum COBRA coverage period ends.
- A special rule applies to the extra 11 months of COBRA coverage in the event that you are disabled. This coverage ends on the last date for which a premium was paid in the month that starts more than 30 days after the Social Security Administration finds that you are no longer disabled. You must inform the COBRA Administrator no more than 30 days after the latter of either the finding that you are no longer disabled or the date on which the qualified beneficiary is informed of his or her obligation to provide notice through the Plan's SPD or the general COBRA notice, and the procedures for providing such notice. All other rules still apply.
- If you added dependents to your COBRA coverage who are not also qualified enrollees, coverage for those dependents ends on the date your coverage ends.

Effect of COBRA Election on Your Rights Under Other Federal Laws

You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your **spouse's** employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you. You may also have other health coverage options available to you through the Health Insurance Marketplace. Visit www.healthcare.gov for further information.

If You Have Questions About COBRA

If you have questions about your COBRA coverage, contact the Plan's COBRA Administrator or the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's COBRA rights, you should notify the Your Cigna Life Service Center about any changes in address for you or any of your **covered dependents**. You should also keep a copy, for your records, of any notices you send to the Your Cigna Life Service Center.

COBRA Appeals

For Eligibility/Election Issues:

If you have a problem with or disagree with a decision about any COBRA eligibility or election issue, you may start the appeal process by filing a formal appeal with the Plan's COBRA Administrator at:

CONEXIS

P.O. Box 223684

Dallas, TX 75222-3684

The eligibility/election appeal process described above under the heading "Eligibility/Election Issues" applies except that the COBRA Administrator, rather than the Your Cigna Life Service Center, will handle your appeal.

If you believe that your right to enroll in COBRA coverage should not have been terminated, you may request that the decision be reconsidered by filing an eligibility/election issue appeal. In your appeal request, please explain why you believe that your right to COBRA coverage during the initial enrollment period was improperly terminated, including all information that you wish to be reviewed. Be sure to include your name, current address, and the names of other covered individuals that you wish to include in your appeal.

For Coverage/Benefits Issues:

The coverage/benefits appeals process described above under the heading "Coverage/Benefits Issues" applies.

HIPAA PRIVACY

In administering the Cigna Medical Plan, the Plan and the **claims administrator** may come into contact with what is considered "protected health information" (PHI) under the Health Insurance Portability and Accountability Act (**HIPAA**). The Plan and the **claims administrator** are permitted to disclose PHI to **Cigna** to enable **Cigna** to carry out plan administration functions or as otherwise permitted by the Standard for Privacy of Individually Identifiable Health Information, and in accordance with the following **HIPAA** privacy protection provisions.

Permitted Uses and Disclosures of PHI by Cigna Corporation

The Plan may only disclose PHI to Cigna Corporation, as sponsor of the Plan, to enable it to carry out plan administration functions or as otherwise permitted by the Standards for Privacy of Individually Identifiable Health Information (HIPAA Privacy Rule) and HIPAA Security Standards (HIPAA Security Rule), found at 45 CFR Parts 160-164 (collectively HIPAA Privacy and Security Rule). Only persons involved with plan administration functions of the Plan may have access to any information disclosed under these **HIPAA** privacy protection provisions. If the persons to whom information is disclosed violate these privacy protection provisions or applicable law, violations may be treated as misconduct under Cigna Corporation's policies and procedures related to employees or a breach of contract in situations involving contracts with third parties. Cigna Corporation shall take appropriate action, up to and including terminating the employment of the employee who commits the violation or terminating the contract with the third party that commits the breach, as applicable.

Cigna Corporation may perform its obligations under these **HIPAA** privacy protection provisions by members of its workforce or those of its subsidiaries and affiliates, or through contractual arrangements with third parties. All such arrangements shall comply with the applicable requirements of these **HIPAA** privacy protection provisions and the HIPAA Privacy and Security Rule.

Unless otherwise indicated, any definitions under these **HIPAA** privacy protection provisions shall have the meaning given them under the HIPAA Privacy and Security Rule.

Privacy Requirements

- Further Disclosure. Cigna Corporation agrees not to use or further disclose the information obtained under these HIPAA privacy protection provisions other than as permitted or required by the Plan document, or as required by law.
- Agents. Cigna Corporation will require that any agents, including any subcontractors, to whom it provides PHI received under these HIPAA privacy protection provisions agree to the same restrictions and conditions that apply to Cigna Corporation with respect to such information.
- Employment Actions. Cigna Corporation agrees not to use or disclose any information received under these HIPAA privacy protection provisions for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by Cigna Corporation.
- Duty to Report. Cigna Corporation will report to the Plan any use or disclosure of information that is inconsistent with the uses or disclosures provided for under these HIPAA privacy protection provisions of which it becomes aware.
- Access. Cigna Corporation will make available any information it holds under these HIPAA privacy protection provisions in order for the Plan to comply with the access requirements under the HIPAA Privacy Rule.
- Amendment. Cigna Corporation will make available any information it holds under these HIPAA privacy protection provisions in order for the Plan to comply with the amendment requirements under the HIPAA Privacy Rule, and will incorporate any amendments to PHI it holds, as required under the HIPAA Privacy Rule.
- Accounting. Cigna Corporation agrees to document and provide a description of any disclosures of protected health information, and information related to such disclosures, as would be required for the Plan to respond to a request by an individual for an accounting of disclosures of PHI in accordance with the HIPAA Privacy Rule.
- Internal Books. Cigna Corporation agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services, for purposes of the Secretary determining the Plan's compliance with the HIPAA Privacy Rule.
- Return of Information. Cigna Corporation will, if feasible, return or destroy all PHI received from the Plan that it maintains in any form, and retain no copies of such information, when it is no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, Cigna Corporation will limit further uses or disclosures of the information to those purposes that make the return or destruction of the information not feasible.
- Adequate Separation. Cigna Corporation will establish adequate separation between it and the Plan, as required under the HIPAA Privacy Rule. Cigna Corporation will limit access to PHI to those employees or classes of employees entitled to use or disclose such information and will require that these employees only may use or disclose such information for plan administration functions.
- Noncompliance. Cigna Corporation will resolve issues of noncompliance with the terms of these HIPAA privacy protection provisions by persons entitled to use or disclose PHI in a timely manner.

HIPAA Security Standards

- Safeguards. Cigna Corporation will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, as defined in the HIPAA Security Rule, that it creates, receives, maintains, or transmits on behalf of the Plan, as required in the HIPAA Security Rule.

- Agents. Cigna Corporation will ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate safeguards to protect such information.
- Security Incidents. Cigna Corporation will report to the Plan any security incident under the HIPAA Security Rule of which it becomes aware.
- Adequate Separation. Cigna Corporation will establish reasonable and appropriate security measures to ensure adequate separation between it and the Plan, in support of the requirements described in these HIPAA privacy protection provisions.

Cigna and the **plan administrator** have also taken specific steps to protect and limit access to PHI. For example, **Cigna** has:

- Designated a Privacy Officer;
- Developed privacy policies and procedures, including a sanctions policy that applies to employees and business **partners** who violate privacy policies;
- Implemented safeguards to protect against improper disclosure of PHI;
- Provided a complaint resolution process; and
- Entered into agreements requiring its business associates to safeguard PHI.

As part of the compliance efforts, a **HIPAA** Notice of Privacy Practices is provided to employees. To receive another copy of the privacy notice, please consult the Appendix to this SPD, go to the *Your Cigna Life* website or contact the Your Cigna Life Service Center at 1.800.551.3539.

ADMINISTRATIVE INFORMATION

If You Have Questions

See "WHO TO CONTACT," page 2

Plan Administration Information

Name of Plan:	Cigna Medical Plan
Plan Number	520
Plan Type	Group Health Plan
Type of Administration	Self-funded; third-party administration (see below)
Plan Administrator	Cigna Health and Welfare Plan Committee C/O Office of the Plan Administrator Cigna Corporation Two Liberty Place, TL05T 1601 Chestnut Street Philadelphia, PA 19192 215.761.2563
Claims Administrator	Cigna Health and Life Insurance Company (**CHLIC**) 900 Cottage Grove Road Bloomfield, CT 06002 Send all claims correspondence to: Cigna HealthCare

	P.O. Box 182223 Nashville, TN 37422-7223
Agent for Service of Legal Process	
	Office of Corporate Secretary Cigna Companies Two Liberty Place, TL16O 1601 Chestnut Street Philadelphia, PA 19192 Process may also be served on the **plan administrator**.
Plan Year	January 1 to December 31
Plan Sponsor	Cigna Corporation, Tax ID Number 06-1059331

The Cigna Medical Plan is self-insured. All valid claims and fees are paid through **CHLIC** and are funded by employee **pre-tax contributions** (except in Puerto Rico) and **Cigna** contributions paid from its general assets.

Discretion of Plan Administrator and Claims Administrator

The **plan administrator** (or its delegate(s)) shall have complete discretion to interpret and construe the provisions of the plans, programs and policies described in this SPD, to determine benefit eligibility for participation and for benefits, make findings of fact, correct errors and supply omissions. All decisions and interpretations of the **plan administrator** (or its delegate(s)) made pursuant to the plans, programs and policies described in this SPD shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious. The **plan administrator** may delegate this discretionary authority to selected service providers.

CHLIC, the **claims administrator**, has the sole discretion to determine whether the Plan provides coverage for any covered person's particular health care situation and the level or amount of any benefit to which he or she might be entitled, as well as to interpret any of the Plan's provisions, including ambiguous and disputed terms and to make any related factual determinations. The **claims administrator's** determinations and interpretations on these issues are final and binding on all parties.

No manager or Human Resources representative is authorized to waive requirements of the Plan, to interpret any Plan terms, to grant any exceptions to any Plan provisions or to contract with employees to provide benefits beyond those described in this SPD.

Continuation of the Plans

Cigna Corporation currently expects to continue the Cigna Medical Plan indefinitely but reserves the right to modify, suspend, or terminate the Plan, and Plan options, or any networks at any time. As a result of any such change, your coverage, **payroll costs** and benefits may be changed or your Plan coverage may be terminated.

Any change in or termination of the Cigna Medical Plan will not affect any covered person's rights as to **covered expenses** he or she incurs while the Plan is still in effect.

Plan Amendments

Neither the Plan nor the benefits described in this document can be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by the **plan administrator**, by any delegate of the **plan administrator**, or by **Cigna** management.

The Plan may be amended at any time by a writing signed by any duly authorized officer of Cigna Corporation or his authorized designee.

ERISA Statements

As a participant in the Cigna Medical Plan, you are entitled to certain rights and protection under **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 in Philadelphia during normal working hours, all documents governing the Plan and a copy of the latest annual report (Form 5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written or electronic mail request to the **plan administrator**, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500) and updated summary plan description. The **plan administrator** may make a reasonable charge for copies.
- Receive a summary of the Plan's annual financial report. The **plan administrator** is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, **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 this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for plan participants, **ERISA** imposes duties on 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under **ERISA**.

Enforce Your Rights

If your claim for a Plan 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.

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

If you have a claim for benefits that has been denied or ignored, in whole or part, you may file suit in a state or federal court.

In addition, if you disagree with the Plan's decision or lack of a decision concerning 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 the 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.

Other Important Notices

The Appendix section contains other important notices about the Plan and your legal rights under the Plan. The Appendix is part of this SPD and you should review it carefully.

GLOSSARY

Here are definitions of some important terms. The definitions are an integral part of the Cigna Medical Plan provisions. These terms appear in bold type in the rest of the SPD.

Affidavit of Domestic Partnership — The formal written statement used to notify **Cigna** that you have a **domestic partner**. The affidavit must be sworn and signed in the presence of a notary. It is available on the *Your Cigna Life* website under Self Service>*Forms/Tools & Resources*>*Domestic Partner Resources*.

bed and board — 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.

Center of Excellence — A **hospital** that, as determined by **Cigna Healthcare** has achieved the highest scores for patient outcomes and cost efficiency in treating selected procedures/conditions in the clinical categories of cardiac, gastroenterology, general surgery, neurologic, obstetrics, orthopedics and respiratory. **Centers of Excellence** are identified in the health care professional directory.

Cigna — Any corporation or other business entity that is owned by Cigna Corporation and that participates in the Cigna Medical Plan. As of January 1, 2018, the companies listed here are eligible to participate in the Cigna Medical Plan.

Bravo Health Mid Atlantic Inc.	Connecticut General Benefit Payment Inc.
Bravo Health Pennsylvania Inc.	GulfQuest, LP
CareAllies, Inc.	HealthSpring Inc.
Cigna Behavioral Health, Inc.	HealthSpring Management of America LLC
Cigna Behavioral Health of California, Inc.	HealthSpring USA LLC
Cigna Dental Health, Inc.	Life Insurance Company of North America
Cigna Dental Health of California, Inc.	NewQuest LLC
Cigna Dental Health of Florida, Inc.	NewQuest Management of Alabama, LLC
Cigna Health& Life Insurance Co.	NewQuest Management of Florida LLC
Cigna HealthCare of Arizona, Inc. Cigna HealthCare of California, Inc.	NewQuest Management of Illinois LLC
Cigna HealthCare of North Carolina, Inc.	NewQuest Management of Northeast, LLC
Cigna Health Management Inc.	Tel-Drug, Inc.
Cigna Holdings, Inc.	Tel-Drug of Pennsylvania, L.L.C.
Cigna International Services, Inc.	
Cigna Life Insurance Company of New York	

Cigna company or companies—Refers collectively to Cigna Corporation and any subsidiary or affiliate in which Cigna Corporation owns directly or indirectly at least an 80-percent interest.

Cigna HealthCare — The division or group that is responsible for medical management.

civil union — A formal relationship legally-recognized in some states, but not under federal law, that gives same-gender couples rights and responsibilities similar to those of a marriage. State law imposes requirements and conditions that you must meet to have a valid **civil union**.

claims administrator — Means the entity described in the "Administrative Information" section of this SPD, who is appointed to administer benefits described in this SPD, including initial and/or appeals claims determinations.

coinsurance — The part of the cost of medical services that you must pay, usually stated as a percent of the amount charged by a health care professional or health care facility. See the charts in Appendix I.

cosmetic therapy or surgery — Therapy or surgery performed to improve or change appearance or self-esteem or to treat symptomatology or psychosocial complaints related to one's appearance.

covered dependent — An **eligible dependent** you elect to cover under the Plan.

covered expenses — Expenses you incur for services and supplies that, as described in this SPD, are covered by the Plan.

covered services — Services that, as described in this SPD, are considered eligible under the Plan.

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

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

custodian — means the custodian of your health savings account under an HSA option. The current custodian is HSA Bank.

deductible — The dollar amount you must pay out-of-pocket (that is, with your money) before the Plan begins to reimburse you for **covered expenses**. When you cover family members, the **deductible** amount is collective. That is, you will pay out-of-pocket for yourself and all covered family members until you reach the designated amount.

domestic partner — A person in a relationship with a **Cigna** employee that meets the following conditions:

- For at least twelve months, you have shared the same principal residence in an intimate, committed relationship of mutual caring and intend to do so indefinitely;
- Each of you agree to be responsible for the other's basic living expenses during the domestic **partnership**, and agree that anyone who is owed these expenses can collect from either of you;
- You are both at least 18 years old and mentally competent to enter binding legal contracts;
- Neither of you is married to anyone, and you are not so closely related by blood that a legal marriage between you would be prohibited for that reason in your state of residence;
- Neither of you has a different **domestic partner** at the time; and
- Neither of you had a different **domestic partner** during the last twelve months.

The employee and his/her **domestic partner** must also have on file with **Cigna** a valid **Affidavit of Domestic Partnership**.

drug list — A listing of approved prescription drugs and related supplies that are covered by the Plan.

eligible dependent — The following persons qualify as an **eligible dependent** of a **regular employee**:

- Your **spouse**.
- Your **partner**.

- Your child — natural or legally adopted, a child placed with you for adoption, your stepchild (that is, the natural or legally-adopted child of your current **spouse**), the natural or legally-adopted child of your **partner**, or a child for whom you are the legal guardian (by court or testamentary appointment), but only if the child is under age 26.
- A person who meets all the above requirements to be an **eligible dependent** child except that the person has passed his/her 26th birthday, but only if the person:
  - Is physically or mentally handicapped and incapable of attending school or engaging in self-sustaining employment prior to the date he/she became eligible for coverage under the Plan; and
  - Before reaching age 26, was continuously covered in a **Cigna company** sponsored Medical Plan or in another employer-sponsored group health plan prior to enrollment in the Cigna Medical Plan.
- A child under age 26 for whom you are legally required to provide health care under a divorce decree or **QMCSO**.

You must provide the **plan administrator** with documented proof (such as copies of official court documents) as evidence of a legal adoption or guardianship or the placement with you of a child for adoption. A child who is placed with you for adoption will become your **eligible dependent** when you become legally obligated to support the child — even if that is before you formally adopt the child.

The **plan administrator** has the right to require proof from you at any time of the eligibility of anyone you claim as an **eligible dependent**. If you do not submit the required proof, Plan coverage for the person you claim as a dependent will be terminated.

If there is evidence that you intentionally claim as your **eligible dependent** a person who does not qualify, you may be subject to disciplinary action, up to and including the termination of your **Cigna** employment, as well as possible legal action.

emergency medical condition — A medical condition involving acute symptoms (including severe pain) that are severe enough so a prudent layperson, with average knowledge of health and medicine, could reasonably expect that lack of immediate medical attention will result in:

- Placing the person's health (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any body organ or part.

emergency services — For someone with an **emergency medical condition**, **emergency services** are:

- A medical screening examination that is within the capability of the emergency department of a **hospital**, including related services routinely available to the emergency department to evaluate the 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.

ERISA — The Employee Retirement Income Security Act of 1974, as amended.

FMLA leave — A leave of absence under the Family and Medical Leave Act. See *Family & Medical Leave* on the *Your Cigna Life* website (go to *Returns & Rewards>Time Away from Work>Family & Medical Leave (FMLA)*).

free-standing surgical facility — 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 blood supplies;
- It maintains medical records;
- It has agreements with **hospitals** for immediate acceptance of patients who need to be hospitalized on an inpatient basis; and
    - It is licensed in accordance with applicable law.

HDHP — A health plan that meets the requirements to qualify as a high deductible health plan under Code section 223.

health assessment — The confidential, online health questionnaire on *www.myCigna.com* that provides an evaluation of an individual's health risks and offers recommendations for reducing those risks through lifestyle changes.

health screening — An evaluation of potential health risks. To qualify for the incentive, it must include the following:

- Height;
- Weight;
- Blood Pressure; and
- Total Cholesterol Level (if recommended by your **physician**).

Healthy Life Personal Health Team — The personal coaching program designed to provide education and one-on-one support to help employees and their covered family members identify health risks, make behavioral changes and maximize the resources available to support them.

HIPAA — The Health Insurance Portability and Accountability Act of 1996.

hospice care program — A coordinated, interdisciplinary program for persons who have a **terminal illness** and for the families of those persons. This program provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness to meet the physical, psychological, spiritual and social needs of dying persons and their families.

hospice care services —Any services provided under a **hospice care program** by a:

- **Hospital**;
- **Skilled nursing facility** or a similar institution;
- Home health care agency;
- **Hospice facility**; or
- Any other licensed facility or agency.

hospice facility —An institution or a part of an institution that:

- Primarily provides care for patients with a **terminal illness**;
- Is accredited by the National Hospice Organization;
- Meets standards established by **Cigna HealthCare**; and
- Fulfills any licensing requirements of the state or locality in which it operates.

hospital — One of the following institutions:

An institution licensed as a **hospital** that:

- Maintains on its premises all facilities necessary for medical and surgical treatment;

- Provides that treatment on an inpatient basis, for compensation, under the supervision of **physicians**; and
- Provides 24-hour service by registered graduate **nurses.**

An institution that qualifies as a **hospital**, a psychiatric **hospital** or a tuberculosis **hospital**, and a provider of services under Medicare, if the institution is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations; or an institution that:

- Specializes in treatment of mental illness, alcohol or drug abuse or other related illness;
- Provides residential treatment programs; and
- Is licensed in accordance with applicable law.

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

legacy QANI employee — means an individual who was employed by QualCare Alliance Networks, Inc. or one of its subsidiaries as of January 3, 2016.

life status change — A term defined in accordance with IRS rules as described in the "Events Affecting Your Plan Coverage, Eligibility or Costs" section of this SPD that describes when you may be permitted to change your elections under the Medical Plan other than during an annual enrollment period. You may make election changes if you have a **life status change** event and the benefit election change you want to make is consistent with your **life status change** event.

maximum reimbursable charges — The maximum amount the Plan pays for out-of-network **covered services**. See discussion under the "Maximum Reimbursable Charges" for a discussion of how the maximum reimbursable charge for **covered services** is determined.

medically necessary/medical necessity — Services or supplies that are determined by **Cigna HealthCare** 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, **Cigna HealthCare** may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

nurse — A registered graduate **nurse**, a licensed practical **nurse** or a licensed vocational **nurse** who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

other health care facility — A licensed facility other than a **hospital** or **hospice facility**. Examples of **other health care facilities** include, but are not limited to, licensed **skilled nursing facilities**, rehabilitation hospitals and subacute facilities.

other health care professional — An individual other than a **physician** who is licensed or otherwise authorized under applicable state law to deliver medical services and supplies. **Other health care professionals** include, but are not limited to, physical therapists, registered **nurses**, licensed practical **nurses**, registered dietitians and licensed acupuncturists.

out-of-pocket maximum — The total amount you must pay out-of-pocket for **covered expenses** in any calendar year. Once you reach your **out-of-pocket maximum**, the Cigna Medical Plan pays most **covered expenses** at 100% of the in-network contracted amount or **maximum reimbursable charges** in the case of out-of network care for the remainder of the calendar year. When you cover family members, the **out-of-pocket maximum** for the family is collective except that the individual in-network **out-of-pocket maximum** applies to each family member. That is, all of what you pay out-of-pocket for **covered expenses** for yourself and all **covered dependents** counts toward meeting the family **out-of-pocket**

maximum and all of what each family member pays out-of-pocket for in-network **covered expenses** counts toward that family member meeting the individual **out-of-pocket maximum**. Once the family **out-of-pocket maximum** is met for all of you, the Cigna Medical Plan will then begin paying you and your **covered dependent's covered expenses** at 100% for the remainder of the calendar year, and once a family member reaches the individual in-network **out-of-pocket maximum**, the Cigna Medical Plan will begin paying that family member's **covered expenses** at 100% for the remainder of the calendar year, regardless of whether the family **out-of-pocket maximum** is met.

P&T Committee — The pharmacy and therapeutics committee of in-network health care professionals and **Cigna HealthCare** medical and pharmacy directors which regularly reviews prescription drugs and related supplies for safety and efficacy, evaluates prescription drugs and related supplies for potential addition to or deletion from the **drug list** and may also set dosage and/or dispensing limits.

partner — A person with whom a **regular employee** has a **domestic partner** arrangement or **civil union** that is legally recognized in the state in which the employee resides.

partnership — A domestic **partnership** arrangement or **civil union** that is legally recognized in the state in which the employee resides.

payroll cost — Your share of the annual cost for Plan coverage that you pay through payroll deduction contributions or direct billing.

pharmacy — A licensed establishment where a pharmacist dispenses prescription drugs.

physician — A licensed medical practitioner who is (a) licensed to prescribe and administer drugs or to perform surgery and (b) practicing within the scope of his or her license. Also, any other licensed medical practitioner whose services are required to be covered by applicable law if he or she is:

- Operating within the scope of his or her license; and
- Performing a service which, when performed by a **physician**, is a **covered service** under the Cigna Medical Plan.

Plan — The Cigna Medical Plan and, where indicated, the HSA medical coverage options.

plan administrator —The person or entity described in the "Administrative Information" section of this SPD.

plan sponsor —The entity described in the "Administrative Information" section of this SPD.

plan year — The calendar year. That is, the 12-month period beginning January 1 and ending December 31.

pre-tax contributions — Contributions deducted from your wages before federal, Social Security, and in most cases, state and local income taxes have been withheld.

preventive generic drugs —A designated group of generic drugs that may keep a disease from manifesting in an individual who has developed risk factors or stop the recurrence of a disease in an individual who has a history of that condition.

primary care physician — A doctor in general or family practice, internal medicine or pediatrics whom you choose to provide or arrange for medical care for you or any of your **covered dependents**.

psychologist — A person who is licensed or certified as a clinical **psychologist**. Where no license or certification exists, "**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 applicable law, to the extent he or she is operating within the scope of his or her license; and performing a service for which benefits are provided under the Cigna Medical Plan when performed by a **psychologist**.

QMCSO — A Qualified Medical Child Support Order – that is, a judgment, decree or court order that provides for health coverage for a child of an employee who participates in the Cigna Medical Plan. To be a **QMCSO**, the order must:

- Specify the employee's name and last known address, and the child's name and last known address;

- Provide a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- State the time period to which it applies; and
- Specify each plan to which it applies.

The **QMCSO** may not require the Cigna Medical Plan to provide coverage for any type or form of benefit that the Plan does not otherwise provide.

regular employee — A person who meets these three conditions and is not in any of the excluded categories described below:

- Employed by **Cigna**;
- Works in the United States, the District of Columbia, Puerto Rico, Guam or the Virgin Islands or is designated by the **plan administrator** as an eligible U.S. expatriate; and
- Is classified in **Cigna** personnel records as a regular full-time employee or a regular part-time employee (for employees hired before January 1, 2014, a regular part-time employee is generally someone who is regularly scheduled to work at least 24 hours a week as of December 31, 2014; for employees hired or rehired on or after January 1, 2014 a regular part-time employee is generally someone who is regularly scheduled to work at least 28 hours a week).

The excluded categories are:

- Hourly, temporary, casual, and leased employees (whether or not within the meaning of Code section 414(n)), staffing or payroll agency employees, even if such persons are later determined by a court, regulatory body or administrative agency to be or have been common law employees of **Cigna** or any participating subsidiary;
- Interns;
- Employees who belong to a collective bargaining unit, unless the applicable collective bargaining agreement provides that unit members are eligible for specified benefit plans;
- Persons who are employed and paid by a company or organization not affiliated with **Cigna** but in some way perform work for **Cigna** under a contract or other business arrangement between **Cigna** and their employer;
- Persons who perform work for **Cigna** as independent contractors or consultants;
    - Persons not classified as full-time employees or regular part-time employees in **Cigna** personnel records unless the Plan Administrator determines, in its sole discretion, that it is necessary for such person to be eligible for the Plan for Cigna to avoid penalties under Code section 4980H; and
- An individual on a temporary assignment to the US (as determined by the **plan administrator** in its sole discretion)

The **plan administrator** has sole discretion to determine whether an employee is a **regular employee**. **Cigna** has not entered into an employment contract with any employee by adopting and maintaining these benefits. Nothing in the Plan documents or in this SPD gives any employee the right to be employed by **Cigna** or to interfere with **Cigna's** right to discharge any employee at any time.

regular tobacco user — A person who has used any form of tobacco product (including cigarettes, clove cigarettes, cigars, pipe tobacco, smokeless tobacco, chewing tobacco or snuff) more than once a month during the 12-month period ending on the date an employee enrolls in the Medical Plan.

skilled nursing facility — A licensed institution (other than a **hospital**) that specializes in:

- Physical rehabilitation on an inpatient basis; or

- Skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of a **physician**; and (c) provides **nurse's** services.

specialist — Any person or organization (licensed as necessary) with specialized medical training and experience that provides medical care in any generally accepted medical specialty or subspecialty.

spouse — A person who is married to a **Cigna** employee, under the laws of any state, possession, or territory of the United States, but excluding a person who is legally separated.

stabilize— To provide someone who has an **emergency medical condition** with the necessary medical treatment to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the person's transfer from a facility.

terminal illness —An illness in which a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a **physician**.

termination of employment date — The date your employment with a **Cigna company** officially ends (usually, your last day of work at **Cigna**).

urgent care — Any medical, surgical, **hospital** or related health care services and testing which are not **emergency services**, but which are determined by the **claims administrator**, 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 including, but not limited to, dialysis, scheduled medical treatments or therapy, or care received after a **physician's** recommendation that you should not travel due to any medical condition.