Cigna
Small Group Open Access Plus Plan

Underwritten by
Cigna Health and Life Insurance Company
1-860-226-6000
900 Cottage Grove Road
Bloomfield, CT, 06002

Effective Date: January 1, 2026
Certificate of Insurance

Cigna Health and Life Insurance Company ("Cigna Healthcare") hereby certifies that it has issued a Small Group Open Access Plus Plan and Certificate of Insurance (herein called the "Plan").

This Plan is governed by the laws of the United States of America and the State of Arizona

This Certificate replaces any previous Certificates of Insurance that may have been issued to You by Cigna Healthcare[SM].

Subject to the provisions of the Plan, each Member, together with his/her eligible Dependents for whom application is initially made and accepted, shall have coverage under the Plan, beginning on the Effective Date shown on the Identification Card, if We receive timely payment of total Premium due to Cigna Healthcare. Issuance of this Certificate by Cigna Healthcare does not waive the eligibility and Effective Date provisions stated in the Plan.

IMPORTANT NOTICES

DIRECT ACCESS TO OBSTETRICIANS AND GYNECOLOGISTS

YOU DO NOT NEED PRIOR AUTHORIZATION FROM THE PLAN OR FROM ANY OTHER PERSON (INCLUDING YOUR PRIMARY CARE PHYSICIAN) IN ORDER TO OBTAIN ACCESS TO OBSTETRICAL OR GYNECOLOGICAL CARE FROM A HEALTH CARE PROFESSIONAL IN OUR NETWORK WHO SPECIALIZES IN OBSTETRICS OR GYNECOLOGY. THE HEALTH CARE PROFESSIONAL, HOWEVER, MAY BE REQUIRED TO COMPLY WITH CERTAIN PROCEDURES, INCLUDING OBTAINING PRIOR AUTHORIZATION FOR CERTAIN SERVICES, FOLLOWING A PRE-APPROVED TREATMENT PLAN, OR PROCEDURES FOR MAKING REFERRALS. FOR A LIST OF PARTICIPATING HEALTH CARE PROFESSIONALS WHO SPECIALIZE IN OBSTETRICS OR GYNECOLOGY, VISIT WWW.MYCIGNA.COM OR CONTACT CUSTOMER SERVICE AT THE PHONE NUMBER LISTED ON THE BACK OF YOUR ID CARD.

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Welcome

Cigna Healthcare would like to welcome you to Our family and let you know that Our priority is your health. If you have any question about Your Plan or need help finding a Provider, Call the phone number listed on the back of Your card.

Introduction

Your medical coverage is provided under a Plan and Certification issued by Cigna Health and Life Insurance Company (Cigna Healthcare). This Plan is a legal contract between You and Us.

Under this Plan, “We,” “Us,” and “Our” mean Cigna Healthcare. “You” or “Your” refers to covered persons under the Plan. “Member“ means You and any eligible Dependents who are enrolled for coverage under this Plan.

The benefits of this Plan are provided only for those services that are Medically Necessary as defined in this Plan and for which the Member has benefits. The fact that a Physician prescribes or orders a service does not, in itself mean that the service is Medically Necessary or that the service is a Covered Service. Consult this Plan or phone Us at the phone number listed on the back of Your ID card if you have any questions regarding whether services are covered.

This Plan contains many important terms (such as “Medically Necessary” and “Covered Service”) that are defined in the section entitled “Definitions.” Before reading through this Plan, be sure that You understand the meanings of these words as they pertain to this Plan.

We provide coverage to You under this Plan based upon the answers submitted by You and Your Family Member(s) on Your signed individual application. In consideration for the payment of the Premiums stated in this Plan, We will provide the services and benefits listed in this Plan to You and Your Family Member(s) covered under the Plan.

If You and/or Your eligible Dependent(s) resides permanently outside of the Service Area, You and he/she has access to Our Open Access Plus national network of Physicians and Hospitals, in addition to Emergency Services, Urgent C, and Out-of-Network services as described elsewhere in this certificate.

Choice of Hospital and Physician: Nothing contained in this Plan restricts or interferes with A Member’s right to select the Hospital or Physician of their choice. A Member may pay more for Covered Services if they are received from a Hospital or Physician that is a Non-Participating Provider

Network
The Network for this Plan is the Open Access Plus Network. The Open Access Plus Network has been specially designed to contain the best Providers that we're confident will serve all of Your needs. You can access up-to-date lists of Our Network Providers and other Open Access Plus Network information at www.cignahealthcare.com or you can login to your account at www.my.cigna.com. Printed directories are available upon request, without charge.

If You Need a Specialist
Your PCP is important to the coordination of your care. While this Plan does not require referrals to visit specialists, if you need specialty care you are encouraged to work with your PCP, who can coordinate your care and assist you in selecting a specialist appropriate for your care.

The referral system can be used to keep your PCP involved in and apprised of all of your health care needs. If you receive Covered Services from a specialist in the Plan's network without a referral, you will not be subject to a penalty, and the claims for those Covered Services will be processed according to the applicable level of benefits.

You will need to submit an Out-of-Network Authorization Request Form to receive the necessary Preauthorization for out-of-network services in this situation. If you would like information on the process or the policy and procedure for requesting out-of-network authorization, please contact Us at the phone number listed on the back of Your ID card

If Your Physician Leaves the Network
If your PCP or specialist ceases to be a Participating Provider, We will notify you in writing of his or her impending termination at least 30 days in advance of the date the PCP leaves the network and provide assistance in selecting a new PCP or identifying a new specialist to continue providing Covered Services. If you are receiving treatment from a Participating Provider at the time his or her Participating Provider agreement is terminated, for reasons other than medical incompetence or professional misconduct, you may be eligible for continued care with that Provider.

Continuity of Care
If your PCP, specialist or facility ceases to be a Participating Provider, We will notify you. Under certain medical circumstances, We may continue to reimburse Covered Expenses from your facility, PCP or a specialist you've been seeing at the Participating Provider benefit level even though he or she is no longer affiliated with Cigna Healthcare's network. If you are undergoing a course of treatment for a Serious and Complex Condition; or undergoing a course of institutional or inpatient care; or scheduled to undergo non-elective surgery, including receipt of postoperative care with respect to such a surgery; or determined to be terminally ill and are receiving treatment for such illness, and continued treatment is Medically Necessary, you may be eligible to receive continuing care from the Non-Participating Provider for a specified time, subject to the treating Provider's agreement. You may also be eligible to receive continuing care if you are pregnant and undergoing a course of treatment for the pregnancy, in which case, continued care may be extended through your delivery and include a period of postpartum care.

Such continuity of care must be approved in advance by Cigna Healthcare, and your Provider must agree to accept Our reimbursement rate and to abide by Cigna Healthcare's policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a Provider who ceases to be a Participating Provider will not be available, such as when the Provider loses his/her license to practice or retires.

You may request continuity of care from Cigna Healthcare after your Participating Provider's termination from Cigna Healthcare's network; start by calling the phone number listed on the back of Your ID card. Continuity of care must be Medically Necessary and approved in advance by Us. Continuity of care will cease upon the earlier of:

- Successful transition of your care to a Participating Provider; or
- Completion of your treatment; or
- The next Annual Open Enrollment Period; or
- The length of time approved for continuity of care ends.

Important Information Regarding Benefits

Prior Authorization Program

Cigna Healthcare provides you with a comprehensive personal health solution medical management program which focuses on improving quality outcomes and maximizes value for you.

PRIOR AUTHORIZATION FOR INPATIENT SERVICES

Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION to a Hospital or certain other facilities MAY RESULT IN A PENALTY OR DENIAL OF PAYMENT FOR THE SERVICES PROVIDED.

Your Participating Provider will submit Prior Authorization to Us for in-network reimbursement. Penalty for failure to obtain Prior Authorization by a Participating Provider for an in-network admission, is the Providers responsibility and will not impact the You.

Prior Authorization for non-emergency admission from Non-Participating Providers can be submitted by the Provider if the Provider is able and willing to file on your behalf. If a Non-Participating Provider is not submitting on your behalf, You must submit by calling the phone number listed on the back of Your ID card.

We will reduce benefits by $750 with respect to charges from Non-Participating Providers for treatment, services and supplies for services which require prior authorization by us but for which You or Your Provider did not request prior authorization.

To verify Prior Authorization requirements for inpatient services, including which other types of facility admissions require Prior Authorization, you can:

- call Cigna Healthcare at the phone number listed on the back of Your ID card, or
- check www.mycigna.com, under “Coverage” then select “Medical.”

Please note that emergency admissions will be reviewed post admission.

Inpatient Prior Authorization reviews both the necessity for the admission and the need for continued stay in the Hospital.

PRIOR AUTHORIZATION FOR OUTPATIENT SERVICES

Prior Authorization is also required for certain outpatient procedures and services in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO CERTAIN ELECTIVE OUTPATIENT PROCEDURES AND SERVICES MAY RESULT IN A PENALTY OR DENIAL OF PAYMENT FOR THE SERVICES PROVIDED.

Your Participating Provider will submit Prior Authorization to Us for reimbursement.

Prior Authorization for non-emergency outpatient procedures and services from Non-Participating Providers can be submitted by the Provider if the Provider is able and willing to file on your behalf. If a Non-Participating Provider is not submitting on your behalf, You must submit by calling the phone number listed on the back of Your ID card.

We will reduce benefits by $750 with respect to charges from Non-Participating Providers for treatment, services and supplies for services which require prior authorization by us but for which You or Your Provider did not request prior authorization.

To verify Prior Authorization requirements for outpatient procedures and services, including which procedures and services require Prior Authorization, you can:

- call Cigna Healthcare at the phone number listed on the back of Your ID card, or
- check www.mycigna.com, under "Coverage" then select "Medical."

If You require a Medically Necessary Covered Service that is not available through an In-Network Provider and We authorized Your In-Network Provider's Referral, We will cover the service from the Out-of-Network Provider as if it were performed by an In-Network Provider.

Upon Your written request, We shall provide or arrange for the completion of covered services from a terminated In-Network Provider from the date of their termination if you were receiving services from the terminated In-Network Provider at the time of the contract termination. Your applicable copay, deductible, or other cost sharing during the period of completion of covered services with a terminated In-Network provider will be the same cost sharing You would pay when receiving care from a current In-Network provider. In order to submit a request for Continuity of Care, you must submit the request in writing within 60 days of Provider Termination by completing a Continuity of Care/Transition of Care Authorization Request Form.

In order to submit a request for Transition of Care, you must submit the request in writing within 60 days of the effective date of your coverage by completing a Continuity of Care/Transition of Care Authorization Request Form.

If you would like information on the process or the policy and procedure for requesting a Continuity of Care or Transition of Care, please contact Member Services at the phone number listed on the back of Your ID card.

If You obtain Prior Authorization for Out-of-Network Services due to an access issue, We will cover the Covered Services at no greater cost to You than if the Covered Services were obtained from an In-Network Provider.

When You visit an Out-of-Network Provider for pre-Authorized Services not available from In-Network Providers, We will:

- Pay the Claim at the amount agreed to by the Out-of-Network Provider and Cigna; or 80th percentile of charges made by Providers of such service or supply in the geographic area where it is received as compiled in a database selected by Us, less any patient Coinsurance, Copayment, or Deductible responsibility under the Plan;
- Pay the Claim at the preferred benefit Cost-Sharing level; and when issuing payment, provide You with an explanation of benefits.

PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. Prior Authorization does not guarantee payment of benefits. Coverage is always subject to other requirements of this Plan's limitations and exclusions, payment of Premium, and eligibility at the time care and services are provided. A Prior Authorization request, once granted or deemed granted, is binding on the Plan and may be relied on by the enrollee and provider. It

may not be rescinded or modified by the Plan or its utilization review agent after the provider renders the authorized health care services in good faith and pursuant to the authorization unless there is evidence of fraud or misrepresentation by the provider.

Retrospective Review

If Prior Authorization was not performed, Cigna Healthcare will use retrospective review to determine if a scheduled admission was Medically Necessary. Cigna Healthcare will also use retrospective review to determine if an emergency admission was Medically Necessary. In the event the services are determined to be Medically Necessary, benefits will be provided as described in this Plan. If it is determined that a service was not Medically Necessary, Cigna Healthcare will not cover any Charges for that service.

PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS

Prior Authorization is required for certain Prescription Drugs and Related Supplies. **For complete, detailed information about Prescription Drug authorization procedures, exceptions and Step Therapy, please refer to the section of this Plan titled "Prescription Drug Benefits."**

To verify Prior Authorization requirements for Prescription Drugs and Related Supplies, including which Prescription Drugs and Related Supplies require authorization, you can:

- call Cigna Healthcare at the phone number listed on the back of Your ID card, or
- log on to www.cigna.com/ifp-drug-lists.

NOTE REGARDING PRIOR AUTHORIZATION OF INPATIENT SERVICES, OUTPATIENT SERVICES AND PRESCRIPTION DRUGS

Some services or therapies may require you to use particular Providers approved by Cigna Healthcare for the particular service or therapy and will not be covered if you receive them from any other Provider regardless of participation status.

Definitions

The following definitions contain the meanings of key terms used in this Plan. Throughout this Plan, the terms defined appear with the first letter of each word in capital letters.

90 Day Retail Pharmacy is a retail Participating Pharmacy that provides all the Covered Services of any other retail Participating Pharmacy, and, through an agreement with Cigna Healthcare, or with an organization contracting on Cigna Healthcare's behalf, dispenses up to a 90-day supply of Prescription Drugs or Related Supplies. Please note not every Participating Pharmacy is a 90 Day Retail Pharmacy, however every Participating Pharmacy can provide a 30-day supply of Prescription Drugs or Related Supplies.

Acceptable Third-Party Payor means one or more of the following:

- the Ryan White HIV/AIDS Program established under Title XXVI of the Public Health Service Act;
- an Indian tribe, tribal organization, or urban Indian organization;
- a local, state or federal government program, including a grantee directed by a government program to make payments on its behalf; or
- an independent private entity that (i) is organized as a not-for-profit organization under state law, (ii) has received a determination from the Internal Revenue Service that the entity qualifies for an exemption from federal income tax under 26 U.S.C. § 501(c)(3), and (iii) makes payments on Your behalf solely on the basis of publicly available criteria and does not in any way consider the health status of any Member in determining whether to make such payments on Your behalf.

Annual Open Enrollment Period means the designated period of time during each Calendar Year, when individuals can apply for coverage for the following Year.

Appeal means a Grievance concerning Adverse Determinations regarding availability, delivery or quality of health care service; claims payment or reimbursement for health care services; matters pertaining to the terms and conditions of the contractual relationship between a covered person and the health carrier; or matters pertaining to the contractual relationship between a healthcare provider and a health carrier.

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorders not otherwise specified.

Brace is 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.

Brand Name Drug (Brand Name) means a Prescription Drug that Cigna Healthcare identifies as a Brand Drug across its book-of-business, principally based on available data resources, including, but not limited to, First Databank or another nationally recognized drug indicator source, that classify drugs or biologics as either Brand or Generic based on a number of factors. Not all products identified as a "Brand Name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the Plan.

Charges means the actual billed charges, except when the Provider has contracted with Cigna Healthcare for a different amount, including where Cigna Healthcare has contracted with an entity to arrange for the provision of Covered Services through contracts with Providers of such services and/or supplies.

Children's Health Insurance Program (CHIP) means an insurance program that provides health coverage to eligible children that do not otherwise qualify for Medicaid.

Cigna Healthcare, We, Our, and Us mean Cigna Health and Life Insurance Company, or an affiliate. Cigna Healthcare is a licensed and regulated insurance company operating throughout the United States.

Cigna LifeSOURCE Designated Transplant Network® Facility is a facility with a transplant program that is included in the Cigna LifeSOURCE Transplant Network®.

Cigna Pathwell Specialty Network is a network that includes, but is not limited to, contracted Physician offices, ambulatory infusion centers, home and outpatient hospital infusion centers, and contracted specialty pharmacies. When the Cigna Pathwell Specialty Network cannot meet the clinical needs of the customer as determined by Cigna Healthcare, exceptions are considered and approved when appropriate.

Cigna Vision is a designated product administered by Us that provides vision services performed by an ophthalmologist or optometrist for Pediatric Vision Care under this plan.

Coinsurance means the percentage of Covered Expenses the Member is responsible for paying after applicable Deductibles are satisfied. **Coinsurance does not include Copayments. Coinsurance also does not include Charges for services that are not Covered Services or Charges in excess of Covered Expenses, or Charges which are not Covered Expenses under this Plan.**

Copayment means a set dollar amount of Covered Expenses the Member is responsible for paying. Copayment does not include Charges for services that are not Covered Services or Charges in excess of Covered Expenses. Copayments are calculated separately from Coinsurance.

Cosmetic Surgery is performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance.

Cost Share is the Deductible, Copayment and Coinsurance amounts you are responsible to pay under the Plan.

Covered Expenses are the expenses incurred for Covered Services under this Plan which Cigna Healthcare will consider for payment under this Plan. Covered Expenses are:

- The Negotiated Rate for Covered Services from Participating Providers.
- The Maximum Reimbursable Charge.

As determined by Cigna Healthcare, Covered Expenses will include all charges made by an entity that has contracted with Cigna Healthcare to arrange, through contracts with Providers, for the provision of any Covered Services.

Covered Expenses may be limited by other specific maximums described in this Plan. Covered Expenses are subject to applicable Deductibles and other benefit limits. **An expense is incurred on the date the Member receives the service or supply.** Covered Expenses may be less than the amount that is actually billed.

Covered Services are Medically Necessary services or supplies that:

- are listed in the benefit sections of this Plan, and
- are not specifically excluded by the Plan, and
- are provided by a Provider that is:
    - licensed in accordance with any applicable federal and state laws,
    - a Hospital, accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another appropriately licensed organization, and
    - acting within the scope of the Provider's license and (if applicable) accreditation.

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

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

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Dedicated Virtual Care Physician means a Physician who is part of a designated network from one or more organizations contracted with Cigna Healthcare to provide certain Virtual Care Services.

Dedicated Virtual Primary Care means a Virtual Care Service provided by a Dedicated Virtual Care Physician for routine primary care needs for conditions such as diabetes, hypertension, cholesterol, asthma, or other non-urgent issues.

Dedicated Virtual Urgent Care means a Virtual Care Service provided by a Dedicated Virtual Care Physician for minor acute medical conditions such as a cold, flu, sore throat, rash or headache.

Deductible means the amount of Covered Expenses that must be paid for Covered Services each Plan Year before benefits are available under this Plan.

Dental Prostheses are dentures, crowns, caps, bridges, clasps, habit appliances, and partials.

Diabetic Equipment includes blood glucose monitors, monitors designed to be used by blind persons; insulin pumps and associated appurtenances, insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices in the injection of insulin and any other required disposable supplies; and podiatric appliances for the prevention of complications associated with diabetes. Diabetic Equipment also includes the repair or maintenance of insulin pumps not covered under a manufacturer's warranty and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

Diabetic Pharmaceuticals and Supplies include visual reading and urine test strips; ketones and protein test strips; blood glucose monitors, therapeutic continuous glucose monitors and the associated supply items on Cigna Healthcare's Prescription Drug List; lancets and lancing devices; insulin and insulin analogs, injection aids;

including devices used to assist with insulin injection and needleless systems; syringes and hypodermic needles, prescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits.

Diabetic Self-Management Training is instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as means of avoiding frequent hospitalization and complications.

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 therapeutic purpose with respect to a particular Illness or Injury, as certified in writing by the attending medical Provider;
- generally are not useful in the absence of Illness or Injury;
- are appropriate for use in the home;
- are of a truly durable nature; and
- are not disposable.

Such equipment includes, but is not limited to, crutches, Hospital beds, wheelchairs, respirators, and dialysis machines.

Effective Date is the date on which coverage under this Plan begins for You and any of Your Family Member(s).

Emergency Medical Condition means a medical condition, including a Mental Health Disorder or Substance Use Disorder that manifests itself by symptoms of sufficient severity, including severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- serious jeopardy to the patient's health, including mental health (or, with respect to a pregnant woman, the health of the woman or her unborn child)
- serious impairment to a bodily function of the patient; or
- serious dysfunction of any bodily organ or part of the patient.
- harm to the patient or others.

Emergency Services means, with respect to an Emergency Medical Condition:

- a medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
- such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to Stabilize the patient.

Essential Health Benefits: To the extent covered under this Plan, expenses incurred with respect to Covered Services, in at least the following categories: ambulatory patient services, Emergency Services, hospitalization, maternity and Newborn care, Mental Health and Substance Use Disorder services, including behavioral health treatment, Prescription Drugs, rehabilitative and Habilitative Services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

Experimental / Investigational / Unproven Procedures: a drug, device or medical treatment or procedure is considered Experimental or Investigational or Unproven if:

- it has not been demonstrated through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or evaluating the condition or Illness for which it is proposed; or
- it has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished, and such approval is required by law; or
- reliable evidence shows it is the subject of ongoing phase I, II, III or IV clinical trial or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the current standard of treatment or diagnosis; or
- reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment of diagnosis.

Reliable evidence means only: the published reports and articles in authoritative, peer-reviewed medical and scientific literature; written protocol or protocols by the treating facility or other facilities studying substantially the same drug, device or medical treatment or procedure; or the medical informed consent used by the treating facility or other facilities studying substantially the same drug, device or medical treatment or procedure.

Family In-Network Deductible applies if You and one or more of Your Family Member(s) are enrolled for coverage under this Plan. It is an accumulation of the Individual In-Network Deductible paid by each Family Member during a Plan Year. Each Member can contribute up to the Individual In-Network Deductible amount toward the Family In-Network Deductible. Once the Family In-Network Deductible amount is satisfied, the remaining Individual In-Network Deductibles will be waived for the remainder of the Plan Year. The amount of the Family In-Network Deductibles are described in the Schedule of Benefits section of this Plan.

Family In-Network Out-of-Pocket Maximum applies if You and one or more of Your Family Member(s) are enrolled for coverage under this Plan. It is an accumulation of the In-Network Deductible, Coinsurance and Copayments each Family Member has accrued during a Plan Year. Each Member can contribute up to his or her Individual In-Network Out-of-Pocket amount toward the Family In-Network Out–of-Pocket Maximum. Once the Family In-Network Out-of-Pocket Maximum has been met in a Plan Year, You and Your Family Member(s) will no longer be responsible to pay Coinsurance or Copayments for medical or Pharmacy services for Covered Expenses incurred during the remainder of that Plan Year from Participating Providers. Non-compliance penalty charges do not apply to the Family In-Network Out-of-Pocket Maximum and will always be paid by you. The amount of the Family In-Network Out-of-Pocket Maximums are described in the Schedule of Benefits section of this Plan.

Family Member means Your spouse, children or other persons enrolled for coverage under this Plan. Family Members who may be eligible for coverage under this Plan are described further in the section of the Plan titled "Who is Eligible for Coverage?"

Family Out-of-Network Deductible applies if You and one or more of Your Family Member(s) are enrolled for coverage under this Plan. It is an accumulation of the Individual Out-of-Network Deductibles paid by each Family Member during a Plan Year. Each Member can contribute up to the Individual Out-of-Network Deductible amount toward the Family Out-of-Network Deductible. Once the Family Out-of-Network Deductible amount is satisfied in a Plan Year, the remaining Individual Out-of-Network Deductibles will be waived for the remainder of the Plan Year. The amount of the Family Out-of-Network Deductible is described in the Schedule of Benefits section of this Plan.

Family Out-of-Network Out-of-Pocket Maximum applies if You and one or more of Your Family Member(s) are enrolled for coverage under this Plan. It is an accumulation of the Out-of-Network Deductible, Coinsurance and Copayment each Family Member has accrued during a Plan Year. Each Member can contribute up to his or her Individual Out-of-Network Out-of-Pocket amount toward the Family Out-of-Network Out-of-Pocket Maximum. Once the Family Out-of-Network Out-of-Pocket Maximum has been met in a Plan Year, You and Your Family

Member(s) will no longer be responsible to pay Coinsurance or Copayments for medical or Pharmacy services for Covered Expenses incurred during the remainder of that Plan Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Family Out-of-Network Out-of-Pocket Maximum and will always be paid by you. The amount of the Family Out-of-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Plan.

Foreign Country Provider is any institutional or professional Provider of medical or psychiatric treatment or care who practices in a country outside the United States of America.

Free-Standing Outpatient Surgical Facility means an Institution which meets all of the following requirements:

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

Generic Drug (Generic) means a Prescription Drug that Cigna Healthcare identifies as a Generic Drug at a book-of-business level principally based on available data resources, including, but not limited to, First Databank or another nationally recognized drug indicator source, that classify drugs or biologics (including biosimilars) as either brand or generic based on a number of factors. Not all products identified as a “Generic” by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the Plan.

Habilitative Services are those services that are:

- designed to assist a child to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame,
- are expected to result in significant and measurable therapeutic or developmental improvement over a clearly defined period of time, and
- are individualized and there is documentation outlining quantifiable, measurable and attainable treatment goals.

Health Plan Value Assessment Committee (HVAC) is a committee comprised of voting and non-voting representatives across various business units of Cigna Healthcare or its affiliates that is duly authorized by Cigna Healthcare to make recommendations regarding coverage treatment of Prescription Drugs and Related Supplies based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to Prescription Drugs and Related Supplies.

Home Health Agencies and Visiting Nurse Associations are home health care Providers that are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home. They must be approved as home health care Providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

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

Hospice Care Services means palliative and supportive medical, nursing and other health services through home or inpatient care that are Covered Expenses provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar Institution, (c) a Home Health Agency and Visiting Nurse Association, (d) a hospice facility, or (e) any other licensed facility or agency under a Hospice Care Program.

Hospital means:

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

The term Hospital will not include any Institution or facility in which a significant portion of the activities include rest, recreation, leisure, or any other services that do not consist exclusively of Covered Services.

Illness is a sickness, disease, or condition of a Member.

Individual Deductible means the amount of Covered Expenses each Member must pay for Covered Services each Plan Year before benefits are available under this Plan. The amount of the Individual Deductible is described in the Schedule of Benefits section of this Plan.

Individual Out-of-Pocket Maximum is an accumulation of Covered Expenses. It includes Deductibles, Copayments and Coinsurance for medical and Prescription Drug Covered Services. Once the Out-of-Pocket Maximum has been met for the Plan Year, for Covered Expenses, you will no longer have to pay any Coinsurance or Copayment for medical or Pharmacy services for Covered Expenses incurred during the remainder of that Plan Year. Non-compliance penalty charges do not apply to the Individual Out-of-Pocket Maximum and will always be paid by you. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Plan.

Infertility is the condition of an otherwise presumably healthy individual who is unable to conceive or produce conception during a period of one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

Infusion and Injectable Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional. Such Specialty Medications may require Prior Authorization or Step Therapy. Refer to the “Prescription Drug Benefits” section of this Plan for Prior Authorization and Step Therapy information.

Injury means an accidental bodily injury.

Institution means an establishment that furnishes food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

Limited Distribution Drugs (LDDs) are drugs with special requirements used to treat conditions affecting only a small percentage of the population. Because of this, the manufacturer may choose to limit the distribution of the drug to only a few pharmacies, or as recommended by the Food and Drug Administration (FDA) for the drug as a condition of its approval of the drug. This type of restricted distribution helps the manufacturer to monitor the inventory of the drug, educate the dispensing pharmacists about the required necessary monitoring, and ensure that any associated risks are minimized.

Maximum Reimbursable Charge (MRC): The MRC represents the maximum amount that Cigna Healthcare will pay an out-of-network health care provider for a covered service under the medical plan.

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

Member means both You, the Plan holder, and all other Family Member(s) who are covered under this Plan.

Medically Necessary or Dentally Necessary services or supplies are those that are determined by Cigna Healthcare to be **all** of the following:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical or dental condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical or dental condition.
- Not primarily for the convenience of any Member, Physician, or another Provider.
- Within generally accepted standards of good medical practice within the community of qualified professionals.
- 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.
- The most appropriate procedure, supply, equipment or service which can be safely provided and that satisfies the following requirements:
    - Must have been proven by scientific studies published in peer-reviewed medical literature to be associated with beneficial health outcomes, demonstrating that the expected health benefits are clinically significant and produce a greater likelihood of benefits, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and
    - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    - For Hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The fact that a Provider prescribed, ordered, recommended or approved a service, supply, treatment or Confinement does not in and of itself make it Medically Necessary or Dentally Necessary or a Medical or Dental Necessity.

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

Mental Health Disorder is defined as a condition that impairs the behavior, emotional reaction or thought processes; these include, but are not limited to depression, psychosis, mania or other psychological symptoms.

Mental Health or Substance Use Disorder Residential Treatment Center means an Institution which:

- specializes in the treatment of psychological and social disturbances that are the result of Mental Health and/or Substance Use Disorder conditions;
- provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians, Other Health Care Professionals under the direct supervision of a Physician, or a healthcare professional independently licensed by a state to provide such services and working within the scope of his/her license (physician assistant, nurse practitioner);
- provides 24-hour care, in which a person lives in an open setting; and
- is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

Negotiated Rate is the lesser of billed Charges or the rate of payment that has been negotiated with a Participating Provider for Covered Services.

Newborn is an infant within 31 days of birth.

Non-Participating Pharmacy/Out-of-Network Pharmacy is a retail or home delivery Pharmacy which Cigna Healthcare has NOT contracted with to provide Prescription Drug services to Members.

Non-Participating Provider/Out-of-Network Provider is a Provider who does not have a Participating Provider agreement in effect with Cigna Healthcare for this Plan at the time services are rendered.

Office Visit means a visit by the Member, who is the patient, to the office of a Physician during which one or more of only the following specific services are provided:

- History (gathering of information on an Illness or Injury)
- Examination
- Medical decision making (the Physician’s diagnosis and plan of treatment)

This does not include other services (e.g. x-rays or lab services) even if performed on the same day.

Orthoses and Orthotic Devices are orthopedic appliances or apparatuses used to support, align, prevent or correct deformities.

Other Health Care Facility means a facility other than a Hospital or hospice facility which is operated by or has an agreement with Cigna Healthcare to render services to Members. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing Facilities, rehabilitation Hospitals and sub-acute facilities. Other Health Care Facilities do NOT include long-term care facilities, residential facilities, care homes, rest homes, or assisted living facilities.

Other Health Care Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and who has an agreement with Cigna Healthcare to render services to Members. Other Health Care Professionals include, but are not limited to, physical therapists, registered nurses and licensed practical nurses.

Out-of-Pocket Maximum is the maximum amount of Deductible, Copayment and Coinsurance each individual or family incurs in Covered Expenses in a Plan Year.

Participating Pharmacy/In-Network Pharmacy is a retail Pharmacy which Cigna Healthcare has contracted with to provide Prescription Drug services to Members or Cigna Healthcare's designated home delivery Pharmacy which Cigna Healthcare has contracted with to provide home delivery Prescription Drug services to Members.

Participating Provider/In-Network Provider means:

- Hospitals, Physicians, and Other Health Care Facilities or Professionals which are: (i) licensed in accordance with any applicable federal and state laws, (ii) accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another organization, if approved by Cigna Healthcare, and (iii) acting within the scope of the practitioner's license and accreditation, and have contracted with Cigna Healthcare to provide services to Members; or
- For the purposes of reimbursement for Covered Expenses, an entity that has contracted with Cigna Healthcare to arrange, through contracts with Providers for the provision of any services and/or supplies, the Charges for which are Covered Expenses.

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

Pediatric Vision Care is examinations and materials (frame and lenses) provided to a Member through the end of the month in which the Member turns 19 years of age. Please refer to the "Pediatric Vision Care" section of this Plan for additional details.

Pharmacy is a duly licensed pharmacy that dispenses Prescription Drugs or Related Supplies in a retail setting or via home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drugs and Related Supplies through mail order.

Pharmacy and Therapeutics (P&T) Committee is a committee comprised of both voting and non-voting clinicians that represent a range of clinical specialties. Consistent with applicable regulatory requirements, the P&T Committee regularly reviews Prescription Drugs and Related Supplies, including new Prescription Drugs and Related Supplies, for safety and efficacy; the findings of these clinical reviews enable the Health Plan Value Assessment Committee (HVAC) to make coverage status recommendations. The P&T Committee's review may be based on, for example, the U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language biomedical journals.

Physical and/or Occupational Therapy/Medicine is the therapeutic use of physical agents other than Prescription Drugs. It comprises the use of physical, chemical and other properties of heat, light, water, electricity, massage, exercise, spinal manipulation and radiation.

Physician means a Physician licensed to practice medicine or any other practitioner who is licensed and recognized as a provider of health care services in the state in which the Member resides; and provides services covered by the Plan that are within the scope of his or her licensure.

Plan is the set of benefits, conditions, exclusions, limitations, and Premiums described in this document, including the Plan specification page, the completed and accepted application for coverage, and any amendments or endorsements to this document.

Planholder means the applicant who has applied for, been accepted for coverage, and who is named as the Planholder on the specification page.

Plan Year is the 12-month period in which Your Plan begins and ends.

Premium means the sum of money paid periodically to Cigna Healthcare by You in order for You and Your Family Members to receive the services and benefits covered by the Plan.

Prescription Drug is a drug, biologic (including a biosimilar), or other Prescription Drug that has been approved by the U.S. Food and Drug Administration (FDA), certain Prescription Drugs approved under the Drug Efficacy Study Implementation review, or Prescription Drugs marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or refill. This definition includes Generic Drugs, Brand Name Drugs, and Specialty Medications.

Prescription Drug List is a listing of covered Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee and the Health Plan Value Assessment Committee (HVAC). The Prescription Drug List is regularly reviewed and updated. You can view the drug list at www.mycigna.com.

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

Primary Care Physician (PCP) is a Physician:

- who is a general practitioner, internist, family practitioner or pediatrician; and
- who has been selected by the Member, or designated by Cigna Healthcare, to provide or arrange for medical care and specialized services for the Member.

Prior Authorization means the approval for certain medical services or Prescription Drugs and Related Supplies that a Participating Provider must request and receive, from Cigna Healthcare for medical services and from the Pharmacy and Therapeutics Committee for Prescription Drugs and Related Supplies, before the services are rendered, or the Prescription Drugs are prescribed, in order for those medical services or Prescription Drugs and Related Supplies to be eligible for benefits under this Plan. You can identify the Prescription Drugs and Related Supplies that require Prior Authorization on the Prescription Drug List at www.mycigna.com.

Prostheses/Prosthetic Appliances and Devices (Prosthetics) are artificial devices designed to replace wholly or partly, an arm or leg. Prostheses/Prosthetic Appliances and Devices include, but are not limited to:

- basic limb Prostheses;
- terminal devices such as hands or hooks.

Provider means:

- a Hospital, a Physician or an Other Health Care Facility or Professional (i) licensed in accordance with any applicable federal and state laws, (ii) accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another organization, if approved by Cigna Healthcare, and (iii) acting within the scope of the practitioner's license and accreditation; or
- an entity that directly or indirectly arranges, through contracts with other Providers, for the provision of any Covered Services.

Reconstructive Surgery is surgery to correct the appearance of abnormal looking features or characteristics of the body caused by birth defects, Injury, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. Reconstructive Surgery includes surgery to improve the function of, or to attempt to create a normal

appearance of, an abnormal craniofacial structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease. Reconstructive Surgery also includes breast reconstruction incident to mastectomy or lumpectomy to restore or achieve breast symmetry. This includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.

Related Supplies are diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for self-injectable outpatient Prescription Drugs that are not dispensed in pre-filled syringes, inhalers, inhaler spacers for the management and treatment of pediatric asthma and other conditions, diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills); disposable needles and syringes needed for injecting covered drugs and supplements.

Schedule of Benefits: A document, incorporated by reference in this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Maximums, and other limits on Covered Services.

Self-administered Injectable Medications are FDA-approved medications which a person may administer to himself/herself by means of intramuscular, intravenous or subcutaneous injection. This does not include insulin prescribed for use by the Member.

Serious and Complex Condition means with respect to an Injured Person:

- In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- a chronic illness or condition that is:
    - life-threatening, degenerative, potentially disabling, or congenital, and
    - that requires specialized medical care over a prolonged period of time.

Service Area: The geographical area, designated by Us and approved by the State of Arizona, in which We provide coverage. The Service Area consists of the state of Arizona.

Skilled Nursing Facility is an Institution that provides continuous skilled nursing services. It must:

- be an Institution licensed and operated pursuant to law, and
- be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician, and
- provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.), and
- maintain a daily medical record on each patient.

This definition excludes any home, facility or part thereof used primarily for rest; a home or facility primarily for the aged or for the care of drug addicts or alcoholics; a home or facility primarily used for the care and treatment of mental diseases or disorders or custodial or educational care.

Smoking Cessation Attempt means 4 tobacco cessation counseling sessions per attempt of at least 10 minutes each (including telephone counseling, group counseling and individual counseling); and one 90-day regimen per attempt of certain Food and Drug Administration FDA-approved tobacco cessation medications (including Prescription medications and over-the-counter medications with a Physician's Prescription; please see the No Cost Preventive Care Drug List at www.mycigna.com for details).

Specialty Medication is a pharmaceutical product, including Self-administered Injectable Medications and Infusion and Injectable Medications considered by Cigna Healthcare to be a Specialty Medication based on the following factors, subject to applicable law:

- whether the Prescription Drug or pharmaceutical product is prescribed and used for the treatment of complex, chronic or rare conditions;
- whether the Prescription Drug or pharmaceutical product has a high acquisition cost; and
- whether the Prescription Drug or pharmaceutical product is subject to limited or restricted distribution, requires special handling, and/or requires enhanced patient education, Provider coordination or clinical oversight.

A Specialty Medication may not possess all or most of the above listed characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug or medical pharmaceutical will be considered a Specialty Medication.

The fact that a drug is considered a Specialty Medication based on the above criteria does not necessarily determine the tier assignment of the Specialty Medication, or whether the Specialty Medication is covered under the Prescription Drug benefit or medical benefit of this Plan.

Specified Diabetic Services and Supplies are particular services and supplies provided or prescribed for the direct treatment of diabetes, including Diabetic Self-Management Training and education, HbA1c, urinalysis, blood kidney function test for nephropathy, metformin, diabetic retinal examination, test strips for blood glucose monitors; visual reading and urine test strips, lancets, syringes and needles. This does not include any other services or supplies not specifically listed here, even if such service or supply is provided or prescribed for the direct treatment of diabetes, nor will these listed services be considered a Specified Diabetic Service or Supply if provided for the treatment of any other diagnosis.

Splint is an appliance for preventing movement of joints or for the fixation of displaced or movable parts.

Stabilize means, with respect to an Emergency Medical Condition, to provide medical treatment as necessary to assure that no material deterioration of the condition is likely if the individual is transferred from a facility, or, with respect to a pregnant woman who is having contractions, to deliver.

Step Therapy is a type of Prior Authorization. Cigna Healthcare may require a Member to follow certain steps before covering some Prescription Drugs and Related Supplies, including Specialty Medications. We may also require a Member to try similar Prescription Drugs and Related Supplies, including Specialty Medications that have been determined to be safe, effective, and more cost effective for most people that have the same condition as the Member. The Prescription Drugs and Related Supplies that require Step Therapy can be identified on the Prescription Drug List at www.mycigna.com.

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. It causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Terminal Illness is an Illness due to which a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Urgent Health Problem means a medical condition that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life (i.e., is not an Emergency Medical Condition).

Virtual Care Service is a suite of medical Covered Services delivered through audio, video and secure internet-based technologies.

We/Us/Our is Cigna Health and Life Insurance Company, Inc. (Cigna Healthcare).

You, Your, and Yourself is the Planholder who has applied for, and been accepted for coverage, and is named as the Planholder on the specification page.

Who Is Eligible For Coverage?

Eligibility Date

Employee Eligibility Date
The Employee is eligible for coverage on the date:

- The eligibility requirements are satisfied as stated in the Employer Group Application, or as otherwise agreed to by the Policyholder and us; and
- The Employee is in an Active Status.

Dependent Eligibility Date
Each Dependent is eligible for coverage on:

- The date the Employee is eligible for coverage, if he or she has Dependents who may be covered on that date;
- The first of the month following the date of the Employee's marriage, for any Dependents (Spouse or Child) acquired on that date;
- The date of birth of the Employee's natural-born Child;
- The date of adoption for an Employee's adopted Child, or the date of placement of the child for the purpose of adoption by the Employee; or
- The date specified in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) for a Child, or a valid court or administrative order for a Spouse, which requires the Employee to provide coverage for a Child or Spouse as specified in such orders.

The Employee may cover his or her Dependents only if the Employee is also covered.
A Child Dependent will continue to be eligible for coverage until the end of the Plan Year in which the Child turns age 26 unless he or she qualifies as a disabled person (if you have a disabled Dependent, please call Us at (855) 672-2784 to request a disabled dependent form).

Enrollment

Employees and Dependents eligible for coverage under the Policy may enroll for coverage as specified in the enrollment provisions outlined below.

Employee Enrollment
The Employee must enroll, as agreed to by the Policyholder and us, within 31 days of the Employee's eligibility date or within the time period specified in the "Special Enrollment" provision.
The Employee is a late applicant if enrollment is requested more than 31 days after the Employee's eligibility date or later than the time period specified in the "Special enrollment" provision. A late applicant must wait to enroll for coverage during the open enrollment period, unless the late applicant becomes eligible for special enrollment as specified in the "Special Enrollment" provision.
Health status will not be used to determine Premium rates. We will not use health status-related factors to decline coverage to an eligible Employee and we will administer this provision in a non-discriminatory manner.

Dependent Enrollment
If electing Dependent coverage, the Employee must enroll eligible Dependents, as agreed to by the Policyholder and us, within 31 days of the Dependent's eligibility date or within the time period specified in the "Special Enrollment" provision.
The Dependent is a late applicant if enrollment is requested more than 31 days after the Dependent's eligibility date or later than the time period specified in the "Special Enrollment" provision. A late applicant must wait to enroll for coverage during the open enrollment period, unless the late applicant becomes eligible for special enrollment as specified in the "Special Enrollment" provision.
Health status will not be used to determine Premium rates. We will not use health status-related factors to decline coverage to an eligible Dependent and we will administer this provision in a non-discriminatory manner.
Newborn and Adopted Dependent Enrollment

A newborn Dependent will be covered from the date of birth to 31 days of age. An adopted Dependent will be automatically covered from the date of adoption or placement of the Child with the Employee for the purpose of adoption, whichever occurs first, for 31 days.
If additional Premium is not required to add additional Dependents and if Dependent Child coverage is in force as of the newborn's date of birth in the case of newborn Dependents or the earlier of the date of adoption or placement of the Child with the Employee for purposes of adoption in case of adopted Dependents, coverage will continue beyond the initial 31 days. You must notify us to make sure we have accurate records to administer benefits.
If Premium is required to add Dependents you must enroll the Dependent Child and pay the additional Premium within 31 days:

- Of the newborn's date of birth; or
- Of the date of adoption or placement of the Child with the Employee for the purpose of adoption to add the Child to your Plan, whichever occurs first.

If enrollment is requested more than 31 days after the date of birth, or date of adoption or placement with the Employee for the purpose of adoption, and additional Premium is required, the Dependent is a late applicant. A late applicant must wait to enroll for coverage during the open enrollment period, unless the late applicant becomes eligible for special enrollment as specified in the "Special Enrollment" provision.

Special Enrollment

If You experience a Triggering Event, You may qualify for a special enrollment period, during which You can enroll for coverage and enroll Your eligible Dependent(s), instead of waiting for the next annual open enrollment period.
Triggering Events for a special enrollment period can be categorized into the following groups:

- Loss of qualifying health coverage;
- Change in household size;
- Change in primary place of living;
- Enrollment or plan error; or
- Other qualifying changes.

Note that failure to pay Premiums, or coverage that is lost on the basis of fraud or an intentional misrepresentation of material fact is never a triggering event.

"Loss of qualifying health coverage" includes:

- You or Your Dependent has lost minimum essential coverage during or at the end of the Plan Year, including but not limited to Medicaid, CHIP, qualifying employer sponsored coverage;
- It is the end of the Plan Year for Your non-Plan Year employer-sponsored coverage;
- Your COBRA coverage has been exhausted;
- You are no longer eligible to be covered as a Dependent due to reaching the limiting age;
- You or Your Dependent loses employer-sponsored health plan coverage because of voluntary or involuntary termination of employment or a reduction in work hours, for reasons other than misconduct; or
- You, Your Spouse or Child loses coverage under an employer-sponsored health plan due to the Employee becoming entitled to Medicare, divorce or legal separation of the covered Employee, or death of the covered Employee.

"Change in household size" includes:

- You gain a Dependent or become a Dependent through marriage;
- You gain a Dependent or become a Dependent through birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order;
- You lose a Dependent due to divorce, legal separation, or death.

"Change in primary place of living" includes:

- You or Your Dependent gain access to new plans as a result of a permanent move;
- Moving solely for medical treatment or vacation are not valid Triggering Events.

“Enrollment or plan error” includes:

- You or Your Dependent’s enrollment or non-enrollment in a plan or inaccurate eligibility determination is a result of a technical error.

“Other qualifying changes” includes:

- You or Your Dependent are survivors of domestic abuse or spousal abandonment.

Triggering Events do not include loss of coverage due to failure to make Premium payments on a timely basis. This includes COBRA Premiums prior to the expiration of Your COBRA coverage and situations allowing for a rescission as specified under federal and state law.
Special enrollment periods begin on the date the triggering event occurs, and end on the 61st day afterwards. Note that for “Loss of qualifying health coverage” and “Change in primary place of living” categories of triggering event, you may also submit an application in the 60 days leading up to the event. Persons who enroll during a special enrollment period will have their coverage Effective Dates determined as follows:

- In the case of birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order, Your coverage is effective on the date the event;
- In the case of marriage, or in the case where You lose minimum essential coverage, coverage is effective on the first day of the following month;
- In the case where the application is submitted before the event, coverage is effective the first day of the month following the event.

In all other cases, the Effective Dates are as follows:

- For an application made between the first and the 15th day of any month, the Effective Date of coverage will be the first day of the following month; or
- For an application made between the 16th and the last day of the month, the Effective Date of coverage will be the first day of the second following month.

Open Enrollment
Eligible Employees or Dependents, who do not enroll for coverage under the Policy following their eligibility date or special enrollment date, have an opportunity to enroll for coverage during the open enrollment period. The open enrollment period is also the opportunity for late applicants to enroll for coverage.
Eligible Employees or Dependents, including late applicants, must request enrollment during the open enrollment period. If enrollment is requested after the open enrollment period, the Employee or Dependent must wait to enroll for coverage during the next open enrollment period, unless they become eligible for special enrollment as specified in the "Special Enrollment" provision.

Effective Date
The provisions below specify the Effective Date of coverage for Employees or Dependents if enrollment is requested within 31 days of their eligibility date or within the time period specified in the "Special Enrollment" provision. If enrollment is requested during an open enrollment period, the Effective Date of coverage is specified in the "Open Enrollment Effective Date" provision.

Employee Effective Date
The Employee's Effective Date provision is stated in the Employer Group Application. The Employee's Effective Date of coverage may be the date immediately following completion of the waiting period, or the first of the month following completion of the waiting period, if enrollment is requested within 31 days of the Employee's eligibility date. The special enrollment date is the Effective Date of coverage for an Employee who requests enrollment within the time period specified in the "Special Enrollment" provision. The Employee Effective Dates specified in this provision apply to an Employee who is not a late applicant.

Dependent Effective Date
The Dependent's Effective Date is the date the Dependent is eligible for coverage if enrollment is requested within 31 days of the Dependent's eligibility date. The special enrollment date is the Effective Date of coverage

for the Dependent who requests enrollment within the time period specified in the "Special Enrollment" provision. The Dependent Effective Dates specified in this provision apply to a Dependent who is not a late applicant.
In no event will the Dependent's Effective Date of coverage be prior to the Employee's Effective Date of coverage.

Newborn and Adopted Dependent Effective Date
The Effective Date of coverage for a newborn Dependent is the date of birth the newborn is not a late applicant.
The Effective Date of coverage for an adopted Dependent is the date of adoption or the date of placement with the Employee for the purpose of adoption, whichever occurs first, if the Dependent Child is not a late applicant.
Premium is due for any period of Dependent coverage whether or not the Dependent is subsequently enrolled, unless specifically not allowed by applicable law. Additional Premium may not be required when Dependent coverage is already in force.

Open Enrollment Effective Date
The Effective Date of coverage for an Employee or Dependent, including a late applicant, who requests enrollment during an open enrollment period, is the first day of the Plan Year as agreed to by the Policyholder and us.

Arizona State Continuation for groups with less than 20 employees
This continuation is only applicable when COBRA does not apply.
This continuation applies to covered employees, dependents and domestic partners.
This continuation is not available to any individual who is entitled to COBRA, Medicare, Medicaid, or coverage under another group health plan.
Continuation is available upon the occurrence of any of the following events as indicated which results in loss of coverage under the plan:

- Termination of employment, excluding termination for gross misconduct;
- Death of employee;
- Divorce, annulment or legal separation;
- Employee’s entitlement to Medicare;
- Dependent child’s loss of dependent status;
- Bankruptcy of the employer or plan sponsor; or
- Reduction of work hours below eligibility for benefits.

Special Provisions: Disabled Qualified Dependent:

- If a qualified dependent is determined by the Social Security Administration to have a disability at the time of a qualifying event then the qualified dependent may be eligible to continue coverage for an additional eleven months if the qualified dependent provides the written determination of disability from the Social Security Administration to the employer within sixty days after the date of that determination and before the end of the eighteen month continuation period. The qualified dependent shall notify the employer within thirty days after the Social Security Administration determines that the qualified dependent no longer has a disability.
  Notice of the right to elect continuation must be sent in writing by the employer to the individual within thirty days after the qualifying event.
  A qualified individual must elect continuation of coverage under this state law within sixty days after the date of the notice and submit the first month premium to the employer within forty five days after the date of election to continue coverage.
  A qualified individual may continue coverage for a maximum of 18 months after the date the continuation coverage begins. If a qualifying event occurs during the eighteen month continuation period, a qualified dependent may be eligible to continue coverage for an additional eighteen months

Special Provisions:

- If the enrollee or qualified dependent elects coverage, coverage continues as if there had been no interruption.

- If the employer fails to provide complete, accurate and timely notice of the right to continue coverage, the enrollee has one hundred twenty days after the date of the notice to elect continuation coverage and pay the required premium and administrative fee.
- If an insurance renewal occurs during the enrollee's or qualified dependent's period of eligibility for continuation coverage, the employer shall notify the enrollee or qualified dependent of any change to the premium due at least thirty days before the change is effective.

Termination of Continuation:
Continuation coverage will terminate on the earliest of the following events, as indicated:

- End of the applicable continuation period noted above
- Termination of the group policy
- End of the period for which premium has been paid
- Dependent ceases to qualify as a dependent
- Entitled to Medicare (contribution due date following eligibility)
- Coverage under another group health plan
- Entitled to Medicaid

Special Provisions:
If the employer replaces the plan with coverage under another plan, the enrollee and any qualified dependents who have continuation coverage have the right to become covered under the new plan for the balance of the period that the enrollee or qualified dependent could have remained covered under the continuation coverage.

Premium:
The individual must pay the premium, to the employer, in a timely manner to maintain continuation coverage. The premium charged cannot exceed 105% of the applicable premium; or 150% for the 11 month disability extension period.

Other Requirements:
If an enrollee is in the military reserve or National Guard and is called to active duty and the enrollee's employment is terminated either after or during the active duty period, the termination is a separate qualifying event, distinct from the qualifying event that may have occurred when the enrollee was called to active duty, and the enrollee and any qualified dependent are eligible for a new eighteen month benefit period beginning on the later of the date active duty ends or the date of employment termination.

If an enrollee is in the military reserve or National Guard and is called to active duty, the following events are qualifying events distinct from the qualifying event that may have occurred when the enrollee was called to active duty:

- The enrollee dies during the period of active duty.
- A divorce or legal separation of the enrollee from the enrollee's spouse occurs.
- A dependent child ceases to be a dependent child under the requirements of the employer's health benefits plan.

If an enrollee who is in the military reserve or National Guard has elected to continue coverage and is thereafter called to active duty and the coverage under the employer's health benefits plan is terminated by the enrollee or the health benefits plan due to the enrollee becoming eligible for a health care program provided by the United States Department Of Defense, the eighteen month period or any other applicable maximum time period for which the enrollee would otherwise be entitled to continuation coverage is tolled during the time that the enrollee is covered under the health care program. Within sixty three days after the federal health care program coverage terminates, the enrollee may elect to continue coverage under the employer's health benefits plan retroactively to the date coverage terminated under the federal health care program for the remainder of the eighteen month period or any other applicable time period, subject to termination of coverage at the earliest of the conditions specified above.

How the Plan Works

Schedule of Benefits

The Schedule of Benefits shows the Individual and Family Deductible and Out-of-Pocket Maximums, and the maximum Covered Expense for each type of benefit.

No benefits are payable unless the Member's coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms, conditions, limitations and exclusions of this Plan.

Participating Hospitals, Participating Physicians and Other Participating Providers

Covered Expenses for services provided by Participating Providers are based on Our Negotiated Rate. Participating Providers have agreed **NOT** to charge more than the Cigna Healthcare Negotiated Rates for Covered Services. Participating Providers may charge the Member for services that are not Covered Services under the Plan. In addition, Participating Providers will file claims with Us for the Member and will request Prior Authorization when it is required.

Non-Participating Hospitals, Non-Participating Physicians and Other Non-Participating Providers

The amount that Cigna Healthcare may cover for services provided by Non-Participating Providers will not exceed the lesser of actual billed Charges, or the Maximum Reimbursable Charge. These services may be subject to additional penalties and/or Deductibles.

Be sure to check with the Provider prior to an appointment to verify that the Provider is currently contracted with Cigna Healthcare.

Out-of-Network Providers: The Maximum Reimbursable Charge for Covered Services provided by an Out-of-Network Provider is determined based on the lesser of:

- The Provider's normal charge for a similar service or supply;
- The amount agreed to by the Out-of-Network Provider and Cigna; or
- A percentage (110%) of a fee schedule We have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable reimbursement for the same or similar service within the geographic market.

In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for Covered Services is determined based on the lesser of:

- The Provider's normal charge for a similar service or supply;
- The amount agreed to by the Out-of-Network Provider and Cigna; or
- The 80th percentile of charges made by Providers of such service or supply in the geographic area where it is received as compiled in a database selected by Us. If sufficient charge data is unavailable in the database for that geographic area to determine the Allowed Amount, then data in the database for similar services may be used:

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Us. Additional information about how We determine the Allowed Amount is available upon request.

Special Circumstances

Your cost sharing for Covered Expenses incurred for the services of a Non-Participating Provider in these special circumstances is indicated in the Schedule of Benefits.

Emergency Services

Covered Expenses incurred for the treatment of an Emergency Medical Condition provided in the emergency department of a Non-Participating Hospital or of an independent freestanding emergency facility are paid as described in the Schedule of Benefits. This includes coverage for additional out-of-network post-stabilization Covered Services as required by applicable federal law. Once the patient is Stabilized and he/she can be transferred to a Participating Hospital, medical payment will be reduced to the Non-Participating Provider benefit level if the Member is not transferred to a Participating Hospital as soon as his or her medical condition permits.

Emergency Services - Outside of the United States

Benefits are provided for services and supplies received from Providers outside of the United States. Coverage is limited to Emergency Services only.
We do not accept assignment of benefits from Providers outside of the United States. This means that the Member is responsible for paying the Provider for services received while outside the United States. The Member may submit a Claim to Us for these services. The Member will be reimbursed up to the Maximum Reimbursable Charge, less the applicable Cost Sharing, for covered Emergency Services. The Maximum Reimbursable Charge may be less than the amount the Member was charged by the Provider. The Member, at their expense, may be held responsible for obtaining an English language translation of Claims and any medical records that may be required. Benefits are subject to all terms, conditions, limitations, and Exclusions of this Plan and will not be more than would be paid if the service or supply had been received in the United States.

Note: if you are using a Non-Participating Provider for any of the reasons above, except for Emergency Services, please be aware that it is your responsibility to obtain any Prior Authorization required for services the Provider performs.

Special Limits

There may be limits applied to certain Covered Services in the form of an Annual maximum on the number of visits, days or events the Plan will cover for a specific type of service. The expenses you incur which exceed specific maximums described in this Plan will be your responsibility. Any special limits applicable to benefits in this Plan are described in the Schedule of Benefits.

The expenses you incur which exceed specific maximums described in this Plan will be your responsibility.

Penalties

A penalty is an amount of Covered Expenses that is:

- Not counted toward any Deductible;
- Not counted toward the Out-of-Pocket Maximum; and
- Not eligible for benefit payment once the Deductible is satisfied.

The following services require Prior Authorization. Penalties may be assessed against your Provider if your Provider fails to obtain Prior Authorization:

- Inpatient Hospital admissions and all other facility admissions,

- Free Standing Outpatient Surgical Facility Services,
- Certain outpatient surgeries and diagnostic procedures.

Penalties are applied before this Plan pays claims.

Covered Services: What the Plan Pays For

Please refer to the Schedule of Benefits for additional benefit provisions which may apply to the information below.

To be eligible for benefits under this Plan, the Provider must be appropriately licensed according to state and local laws and accredited to provide services within the scope of the Provider's license and accreditation.

Before this Plan pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After you satisfy the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

The benefits described in this section will be paid for Covered Expenses incurred on the date You and Your Family Member(s) receive the service or supply for which the Charge is made. These benefits are subject to all terms, conditions, Deductibles, penalties, exclusions, and limitations of this Plan. All services will be paid at the percentages indicated in the Schedule of Benefits and subject to limits outlined in the section entitled "How the Plan Works."

Following is a general description of the supplies and services for which the Plan will pay benefits if such services and supplies are Medically Necessary and for which you are otherwise eligible as described in this Plan.

If you are inpatient in a Hospital or Other Health Care Facility on the day your coverage begins, We will pay benefits for Covered Services that you receive on or after your first day of coverage related to that inpatient stay as long as you receive Covered Services in accordance with the terms of this Plan. These benefits are subject to any prior carrier's obligations under state law or contract.

Inpatient Services and Supplies at a Hospital or Free-Standing Outpatient Surgical Facility

For any eligible condition, this Plan provides indicated benefits for Covered Expenses for:

- Inpatient services and supplies provided by the Hospital except private room Charges above the prevailing two-bed room rate of the facility.
- Outpatient services and supplies including those in connection with Emergency Services, outpatient surgery and outpatient surgery performed at a Free-Standing Outpatient Surgical Facility.
- Diagnostic/therapeutic lab and x-rays.
- Anesthesia and inhalation therapy.

Payments of Inpatient Covered Expenses are subject to these conditions:

- Services must be those which are regularly provided and billed by the Hospital or Free-Standing Outpatient Surgical Facility.
- Services are provided only for the number of days required to treat the Member's Illness or Injury.

Note: No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Inpatient Services at Other Health Care Facilities

For any eligible condition, this Plan provides indicated benefits for Covered Expenses for inpatient services and supplies provided by an Other Health Care Facility, except private room Charges above the prevailing two-bed room rate of the facility. Payment of benefits for Other Health Care Facility services is subject to all of the following conditions:

- The Member must be referred to the Other Health Care Facility by a Physician.
- Services must be those which are regularly provided and billed by an Other Health Care Facility.
- The services must be consistent with the Illness, Injury, degree of disability and medical needs. Benefits are provided only for the number of days required to treat the Illness or Injury, subject to any maximum number of covered days per Plan Year shown in the Schedule of Benefits.
- Services covered under this benefit cannot be provided in a less intense setting, such as outpatient services provided at home.
- The Member must remain under the active medical supervision of a Physician treating the Illness or Injury for which he or she is confined in the Other Health Care Facility.

Note: No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Hospice Care

This Plan provides benefits for Covered Expenses for Hospice Care Services under a Hospice Care Program for Members who have a Terminal Illness and for the families of those persons, including palliative and supportive medical, nursing and other health services through home or inpatient care and bereavement counseling for the Family Members for up to 12 months following the death of the terminally ill Member.

To be eligible for this benefit, the Hospice Care Services Provider must be appropriately licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of Terminal Illness. The Provider must also be approved as a Hospice Care Services Provider under Medicare and the Joint Commission on Accreditation of Health Care Organizations or by the appropriate agency of the state in which this Plan is sold.

In order to be eligible for benefits for a Hospice Care Program, the Member must be suffering from a Terminal Illness, as certified by his or her Physician, notice of which is submitted to Us in writing.

The Physician must consent to the Hospice Care Program and must be consulted in the development of the treatment plan.

Professional and Other Services

This Plan provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- Virtual Care Services;

- Services of an anesthesiologist or an anesthetist;
- Outpatient diagnostic radiology and laboratory services;
- Radiation therapy, chemotherapy and hemodialysis treatment;
- Surgical implants, except for cosmetic and dental;
- Surgical procedures for sterilization;
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products;
- Internal Prosthetic Appliances and Devices/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.
- Hearing aids and associated exam for device testing and fitting, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). Limited to 1 device per ear per Plan Year. A hearing aid is any device that amplifies and delivers speech and other sounds at levels equivalent to that of normal speech and conversation.

Allergy Testing
We cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also cover allergy treatment, including injections, serums, and antigen administration desensitization/treatment.

Bariatric Surgery
We cover the following bariatric Surgery procedures, when criteria in the clinical guideline pertaining to bariatric Surgery are met:
- Open roux-en-y gastric bypass (RYGBP);
- Laparoscopic roux-en-y gastric bypass (RYGBP);
- Laparoscopic adjustable gastric banding (LAGB);
- Open biliopancreatic diversion with duodenal switch (BPD/DS);
- Laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS);
- Open sleeve gastrectomy; and laparoscopic sleeve gastrectomy (LSG).

Biomarker Testing
We cover biomarker testing for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a Member's disease or condition to guide treatment decisions when the test provides clinical utility as demonstrated by medical and scientific evidence, including any of the following:
- Labeled indications for tests that are approved or cleared by the FDA or indicated tests for a drug approved by the FDA;
- CMS national coverage determinations or Medicare administrative contractor local coverage determinations;
- Nationally recognized clinical practice guidelines and consensus statements.

Biomarker
- Means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacological responses to a specific therapeutic intervention;
- Includes gene mutations or protein expression.

Biomarker Testing
Means the analysis of patient's tissue, blood, or other biospecimen for the presence of a biomarker

- Includes single-analyte tests, multiplex panel tests, and whole genome sequencing.

Durable Medical Equipment

This Plan provides benefits for Covered Expenses incurred for rental or purchase of medical equipment and/or supplies that meet all of the following requirements:

- Are ordered by a Physician;
- Serve a medical purpose and are expected to be of no further use when medical need ends;
- Are not primarily for comfort or hygiene;
- Are not for environmental control;
- Are not for exercise; and
- Are manufactured specifically for medical use.

Note: Medical equipment and supplies must meet all of the above requirements in order to be eligible for benefits under this Plan. The fact that a Physician prescribes or orders equipment or supplies does not necessarily qualify the equipment or supply for payment. Coverage for Durable Medical Equipment is limited to the most cost-effective alternative.

Cigna Healthcare determines whether the item meets these conditions and whether the equipment falls under a rental or purchase category.

Rental Charges that exceed the reasonable purchase price of the equipment are not covered, unless the equipment has previously been determined by Cigna Healthcare to fall into a continuous rental category and requires frequent maintenance and servicing.

Coverage for repair, replacement or duplicate equipment is provided only when approved as Medically Necessary. All maintenance and repairs that result from a Member's misuse are the Member's responsibility.

Enteral Nutrition

The Plan includes coverage for medical foods that are specially formulated for enteral feedings or oral consumption.
Coverage includes charges made for medical foods to treat inherited metabolic disorders. Metabolic disorders triggering medical food coverage are: part of the newborn screening program as prescribed by Arizona statute; involve amino acid, carbohydrate or fat metabolism; have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and require specifically processed or treated medical foods that are generally available only under the supervision and direction of a Physician, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.
For the purpose of this section, the following definitions apply:

- "Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the new born screening program as prescribed by Arizona statute.
- "Medical Foods" means modified low protein foods and metabolic formula.
- "Metabolic Formula" means foods that are all of the following: formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy; processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and essential to a person's optimal growth, health and metabolic homeostasis.
- "Modified Low Protein Foods" means foods that are all of the following: formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy; processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and essential to a person's optimal growth, health and metabolic homeostasis.

For other diagnosis not specified above, coverage for enteral nutrition and supplies required for enteral feedings is provided when all of the following conditions are met:

- It is necessary to sustain life or health.
- It is used in the treatment of, or in association with, a demonstrable disease, condition or disorder.
- It requires ongoing evaluation and management by a Physician.
- It is the sole source of nutrition or a significant percentage of daily caloric intake.

Coverage for enteral nutrition does not include:

- Regular grocery products that meet the nutritional needs of the patient (e.g. over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or
- Medical food products that: are prescribed without a diagnosis requiring such foods; are used for convenience purposes; have no proven therapeutic benefit without an underlying disease, condition or disorder; are used as a substitute for acceptable standard dietary intervention; or are used exclusively for nutritional supplementation.
- For non-inherited disorders, enteral nutrition is considered Medically Appropriate when the insured has:
- a permanent non-function or disease of the structures that normally permit food to reach the small bowel; or
- a disease of the small bowel which impairs digestion and absorption of an oral diet consisting of solid or semi-solid foods.

Nutritional Formulas

This Plan covers for medical foods, metabolic supplements and Gastric Disorder Formula to treat inherited metabolic disorders. Metabolic disorders triggering medical food coverage are: part of the newborn screening program as prescribed by Arizona statute; involve amino acid, carbohydrate or fat metabolism; have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and require specifically processed or treated medical foods that are generally available only under the supervision and direction of a Physician, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

For the purpose of this section, the following definitions apply:

- "Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the new born screening program as prescribed by Arizona statute.
- "Medical Foods" means modified low protein foods and metabolic formula.
- "Metabolic Formula" means foods that are all of the following: formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy; processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and essential to a person's optimal growth, health and metabolic homeostasis.
- "Modified Low Protein Foods" means foods that are all of the following: formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy; processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and essential to a person's optimal growth, health and metabolic homeostasis.

Medical and Surgical Supplies

The Plan includes coverage for medical and surgical supplies that are Medically Necessary, serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, Splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly, creams or lotions.

Ambulance Services

This Plan provides benefits for Medically Necessary Covered Expenses incurred for the following ambulance services:

- Base Charge, mileage and non-reusable supplies of a licensed ambulance company for transportation to and from a Hospital or Skilled Nursing Facility.
- Monitoring, electrocardiograms (EKG's or ECG's), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriate licensed person must render the services.
- Ambulance transportation for emergency situations to the nearest facility capable of handling the emergency.

This coverage includes Medically Necessary transport by air and/or water ambulance when:

- The point of pickup is not accessible by ground ambulance;
- Ground ambulance transport is not feasible due to the distance to the nearest Hospital capable of handling the patient's Illness or Injury or other obstacles to ground transport; or

- The time required for ground ambulance transport would impede timely and appropriate medical care.

Rehabilitative Therapy Services (Physical Therapy, Occupational Therapy, Chiropratic, Osteopaths and Speech Therapy)

This Plan provides benefits for Covered Expenses incurred for the following rehabilitative services:

- Therapeutic use of heat, cold, exercise, electricity or ultraviolet light; or
- Manipulation of the spine; or
- Massage to improve circulation, strengthen muscles, encourage return on range of motion, as part of treatment for an Illness or Injury; and
- Services for the necessary care and treatment of loss or impairment of speech.

Benefits are provided up to any maximum number of visits shown in the Schedule of Benefits. For the purposes of this benefit, the term “visit” includes any outpatient visit to a Physician during which one or more Covered Services are provided.

All supplies and additional fees charged in conjunction with these services will be included in the payment of benefits for the visit and will not be reimbursed in addition to the visit.

Pulmonary and Cardiac Rehabilitation Services

This Plan provides benefits for Covered Expenses incurred for pulmonary rehabilitation, and for Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

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

Habilitative Services

This Plan provides benefits for Covered Expenses designed to assist you in developing a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame and are payable as stated in the Schedule of Benefits.

This Plan provides benefits for Covered Expenses incurred for the following Habilitative Services:

- Therapeutic use of heat, cold, exercise, electricity or ultraviolet light;
- Manipulation of the spine;
- Massage, to improve circulation, strengthen muscles, encourage return on range of motion, as part of treatment for an Illness or Injury;

- Services for the necessary care and treatment of loss or impairment of speech; and
- Services designed to assist a child to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame.

Benefits are provided up to any maximum number of visits shown in the Schedule of Benefits. For the purposes of this benefit, the term “visit” includes any outpatient visit to a Physician during which one or more Covered Services are provided.

All supplies and additional fees charged in conjunction with these services will be included in the payment of benefits for the visit and will not be reimbursed in addition to the visit.

Mental Health and Substance Use Disorder Services

This Plan provides benefits for Covered Services as indicated below for inpatient and outpatient evaluation and treatment of Mental Health and Substance Use Disorders. Mental Health and Substance Use Disorder services that are not covered by this Plan are listed in the “Exclusions and Limitations: What Is Not Covered by This Plan” section.

IMPORTANT NOTE ON MENTAL HEALTH & SUBSTANCE USE DISORDER COVERAGE:

Covered Services which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be covered at the Cost Share shown in the sections titled “Mental Health Disorder” and “Substance Use Disorder” within the Schedule of Benefits below. Any age, day, dollar or visit maximums are not applicable to services used to diagnose or treat a Mental Health or Substance Use Disorder condition.

Covered medical services received for ambulance Charges provided for Mental Health or Substance Use Disorders will be payable according to the benefits outlined in “Hospital Emergency Room” within the Schedule of Benefits below.

Inpatient Services
Benefits include Covered Services provided by a Hospital for the evaluation and treatment of Mental Health and/or Substance Use Disorder during an inpatient admission for acute care for conditions such as:

- a patient who presents a danger to self or others;
- a patient who is unable to function in the community;
- a patient who is critically unstable;
- a patient who requires acute care during detoxification; and
- the diagnosis, evaluation and acute treatment of addiction to alcohol and/or drugs.

Benefits also include Covered Services provided by a Mental Health or a Substance Use Disorder Residential Treatment Center for a Member who is confined in a Hospital or a Mental Health or Substance Use Disorder Treatment Residential Treatment Center as a registered bed patient, upon the recommendation of a Physician. Covered Services include hospitalization and residential treatment services provided by a Hospital or a Mental Health or Substance Use Disorder

Residential Treatment Facility for the evaluation and treatment of psychological and social disturbances resulting from a subacute Mental Health or Substance Use Disorder condition that prevents a Member from participating in treatment within the community and/or requires rehabilitation.

Outpatient Services
Benefits include Covered Services by Providers who are qualified to treat Mental Health or Substance Use Disorders, when treatment is provided on an outpatient basis for 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 thinking; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention), outpatient testing, and assessment, Applied Behavior Analysis and medication management when provided in conjunction with a consultation. Covered Services include:

- Treatment of mental health conditions in an individual, family, group, partial hospitalization or intensive outpatient therapy setting.
- Treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual, family, group, partial hospitalization or intensive outpatient therapy setting.
- Intensive outpatient structured therapy programs consist of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health or Substance Use Disorder program. Intensive outpatient structured therapy programs provide a combination of individual, family and/or group therapy totaling 9 or more hours in a week.
- Mental Health or Substance Use Disorder partial hospitalization services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health or Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

Dental Care

This Plan provides benefits for dental care for an accidental Injury to natural teeth, subject to the following:

- services must begin within the 6 months following the date of Injury;
- no benefits are available to replace or repair existing Dental Prostheses even if damaged in an eligible accidental Injury; and
- damage to natural teeth due to chewing or biting is not considered an accidental Injury under this Plan.

Pregnancy and Maternity Care

Your Plan provides pregnancy and post-delivery care benefits for You and Your Family Members.

All comprehensive benefits described in this Plan are available for maternity services. Comprehensive Hospital benefits for routine nursery care of a Newborn child are available so long

as the child qualifies as an eligible dependent as defined in the section of this Plan titled “Who is Eligible for Coverage?”

The mother and her Newborn child are entitled, under federal law, to inpatient Hospital coverage for a period of 48 hours following an uncomplicated vaginal delivery; and 96 hours following an uncomplicated delivery by cesarean section. We will not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a Provider obtain authorization for prescribing a length of stay that does not exceed the above periods. Any decision to shorten the period of inpatient care for the mother or the Newborn must be made by the attending Physician in consultation with the mother. If a decision is made between a mother and doctor to discharge a mother or Newborn child from inpatient care before the 48 or 96 hour time period, coverage for timely post-delivery care is available. Benefits extend to the delivery expenses incurred at birth by the birth mother in connection with the birth of an adopted child.

We cover breastfeeding support and supplies. Coverage includes comprehensive lactation support services (including consultation; counseling; education by clinicians and peer support services; and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to optimize the successful initiation and maintenance of breastfeeding. Breastfeeding equipment and supplies include, but are not limited to, double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Breastfeeding equipment may also include
equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those who need additional services.

This Plan provides benefits for complications of pregnancy. Benefits are available for other pregnancy and maternity care as indicated above under “Pregnancy and Maternity Care.”

Birth Mother/ Surrogate Expenses

Charges incurred at birth for the delivery of a child only to the extent that they exceed the birth mother's coverage, if any, provided: that child is legally adopted by you within one year from date of birth; you are legally obligated to pay the cost of the birth; you notify Cigna of the adoption within 60 days after approval of the adoption or a change in the insurance policies, plans or company; and you choose to file a claim for such expenses subject to all other terms of these Medical Benefits.

Preventive Care Services

The Plan provides benefits for routine preventive care services. Payment will be provided for Covered Expenses for preventive care services including the following:

- Routine physical exams, including guidance and counseling regarding Substance Use Disorder, alcohol misuse, tobacco use, obesity, exercise and healthy diet/nutritional counseling;
- Two Smoking Cessation Attempts (maximum of 4 counseling sessions per attempt); Smoking cessation aids both prescribed and over-the counter will be covered. Over the counter aids are covered at no cost, and without numerical limits. Prescription Drugs for smoking cessation

treatment are covered at no cost, and without numerical limits, under the Prescription Drug benefit;

- Mammograms for breast cancer screening performed on dedicated equipment, including coverage for tomosynthesis, magnetic resonance imaging, ultrasounds, and other modalities for diagnosing breast cancer, on referral by a patient's Physician, not fewer than: a baseline mammogram for women ages 35 to 39, inclusive; a mammogram for women ages 40 to 49, inclusive, every two years or more frequently based on the attending Physician's recommendation; or a mammogram every year for women age 50 and over.
- Annual prostate-specific antigen test (PSA);
- Colorectal cancer screening;
- Osteoporosis screening;
- Obstetrical and gynecological services when provided by qualified providers for pregnancy, well-women gynecological exams, primary and preventive gynecological care and acute gynecological conditions. Amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, are not covered unless Medically Necessary to determine the existence of a gender-linked genetic disorder;
- Items or services that have an A or B rating in current recommendations of the U. S. Preventive Services Task Force (USPSTF) A and B Recommendations | United States Preventive Services Taskforce;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; https://www.cdc.gov/vaccines/acip/index.html
- 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; https://www.hrsa.gov/ ; and
- For women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; https://www.hrsa.gov/.
- Preexposure prophylaxis (PrEP) with antiretroviral therapy for members at high-risk of HIV acquisition. Please note: Certain PrEP drugs are covered as Preventive Medications at no cost to You only when specific conditions are met. Such as when, according to Your Provider, a preventive PrEP drug is not medically appropriate, or you are contraindicated or unable to take it. If so, Your Provider may contact Member Services to request an exception. If the requested PrEP drug meets the exception criteria, they will be covered at no cost.

Detailed information is available at www.healthcare.gov/coverage/preventive-care-benefits.

Note: Covered Services do not include routine examinations, care, screening or immunization for travel (medications used for travel prophylaxis, except anti-malarial drugs), employment, school or sports.

Family Planning

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

Genetic Testing

This Plan provides benefits for Covered Expenses for charges made for genetic testing that uses a proven testing method for the identification of genetically linked inheritable disease. Genetic testing is covered only if:

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

Genetic counseling is covered when covered genetic testing is under consideration or planned or if a Member is at risk for an inherited disease or carrier state.

Autism Spectrum Disorders

This Plan provides benefits for Covered Expenses for Members for Charges made for:

- diagnosis of Autism Spectrum Disorders; and
- treatment of Autism Spectrum Disorders.

Treatment for Autism Spectrum Disorders shall include the following care prescribed, provided, or ordered for an individual diagnosed with an Autism Spectrum Disorder by

- a Physician licensed to practice medicine in all its branches or
- a certified, registered, or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a Physician licensed to practice medicine in all its branches.

Except for inpatient services, upon request from Cigna Healthcare and not more than once every 12 months, a Provider of treatment for Autism Spectrum Disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is Medically Necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, Cigna Healthcare may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

Covered Services include:

- Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
- Psychological care, meaning direct or consultative services provided by a licensed psychologist.

- Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including Applied Behavior Analysis, that are intended to develop, maintain, and restore the functioning of an individual.
- Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:
    - self-care and feeding,
    - pragmatic, receptive, and expressive language,
    - cognitive functioning,
    - Applied Behavior Analysis, intervention, and modification,
    - motor planning, and
    - sensory processing.

Organ and Tissue Transplants and Related Specialty Care

All transplant services and related specialty care services, other than cornea transplants, are covered when received at Cigna LifeSOURCE Transplant Network® Facilities.

Transplant services and related specialty care services received at Participating Provider facilities specifically contracted with Cigna for those transplant services and related specialty care services, other than Cigna LifeSOURCE Transplant Network® Facilities, are payable at the In-Network level.

Transplant services and related specialty care services received at any other facility, including non-Participating Provider facilities and Participating Provider facilities not specifically contracted with Cigna for transplant services and related specialty care services, are covered at the Out-of-Network level.

This coverage is subject to the following conditions and limitations.

Coverage is provided for both the recipient and donor of a covered transplant under the recipient's plan.

Coverage will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant surgery. 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 intestinal, including small bowel/liver or multivisceral.
- The evaluation, preparation and delivery of the donor organ.
- The removal of the organ from the donor. Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a deceased or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search

and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Cornea transplants are not covered by the LifeSOURCE Provider contracts but are covered when received from a Participating Provider facility.

NOTE: Most In-Network Provider facilities are NOT contracted to provide transplant services or NOT identified as a Cigna LifeSOURCE Designated Transplant Network® Facility. For more information on whether an in-network facility is contracted with Cigna LifeSOURCE Designated Transplant Network® Facility to provide transplant services, contact your LifeSOURCE case manager or call 1-800-287-0539.

Transplant Travel Services

Coverage is provided for transportation and lodging expenses incurred by you in connection with a pre-approved organ/tissue transplant that if reimbursed by Cigna Healthcare would be characterized by the Internal Revenue Service as non-taxable income pursuant to Publication 502, and subject to the following conditions and limitations. Benefits for transportation and lodging are available to you only if you are the recipient of a pre-approved organ/tissue transplant from a Cigna LifeSOURCE Designated Transplant Network® Facility. The term “recipient” includes a Member receiving authorized transplant-related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the Member receiving the transplant will include charges for:

- transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); and
- lodging while at or traveling to and from the transplant site.

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

Travel expenses that are NOT covered include, but are not limited to the following:

- travel costs incurred due to travel within less than sixty (60) miles of your home;
- food and meals;
- laundry bills;
- telephone bills;
- alcohol or tobacco products; and
- charges for airline transportation that exceed coach class rates.

Note: Transplant travel benefits are not available for corneal transplants.

Transplant travel services are only available when the Member is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available where the Member is a donor.

Travel expenses for organ and tissue transplants are limited to any maximum shown in the Schedule of Benefits.

Diabetes

Covered Services for diabetes are covered on the same basis as any other medical condition. This Plan provides benefits for Covered Expenses including outpatient Diabetic Self-Management Training and education, Diabetic Equipment and Diabetic Pharmaceuticals and Supplies for the treatment of type 1 diabetes, type 2 diabetes, and gestational diabetes mellitus.

Foreign Country Providers

This Plan provides benefits for Covered Expenses for services and supplies received from Foreign Country Providers for medical emergencies and other urgent situations where treatment could not have been reasonably delayed until the Member was able to return to the United States.

Cigna Healthcare does not accept assignment of benefits from Foreign Country Providers. You and Your Family Members can file a claim with Cigna Healthcare for services and supplies from a Foreign Country Provider, but any payment will be sent to the Member. The Member is responsible for paying the Foreign Country Provider. The Member at their expense is responsible for obtaining an English language translation of Foreign Country Provider claims and any medical records that may be required. Benefits are subject to all terms, conditions, limitations, penalties and exclusions of this Plan and will not be more than would be paid if the service or supply had been received in the United States.

Home Health Care Services

This Plan includes benefits for Covered Expenses for home health services when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility. Home health services are provided only if Cigna Healthcare has determined that the home is a medically appropriate setting.

Home health services are those skilled health care services that can be provided during visits by Other Health Care Professionals, including Medically Necessary services of a medical social worker. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Necessary consumable medical supplies and home infusion therapy administered or used by Providers in providing home health services are covered. Home health services do not include services by a person who is a member of Your family or Your dependent's family, or who normally resides in Your house or Your dependent's house even if that person is a Provider. Skilled nursing services or private duty nursing services provided in the home are subject to the home health services benefit terms, conditions and benefit limitations.

This Plan provides benefits for Covered Expenses for home health care prescribed by the Physician treating your condition when the following criteria is met:

- The care described in the plan of care must be for intermittent skilled nursing, or Physical, Occupational, and other short-term rehabilitative therapy services.
- The Member must be confined at home, in lieu of hospitalization, under the active supervision of a Physician.

- The home health agency delivering care must be certified within the state where the care is received.
- The care that is being provided is not Custodial Care.

The Physician must be treating the Illness or Injury that necessitates home health care.

If the Member is a minor or an adult who is dependent upon others for non-skilled care, Custodial Care and/or activities of daily living (e.g., bathing, eating, etc.), home health care will be covered only during times when there is a family member or care giver present in the home to meet the Member's non-skilled care and/or Custodial Care needs.

Mastectomy and Related Procedures

This Plan provides benefits for Covered Expenses for Hospital and professional services under this Plan for mastectomy and lymph node dissection for the treatment of breast cancer and for the treatment of physical complications of all stages of mastectomy, including lymphedemas, whether or not the mastectomy occurred while the Member was covered under this Plan. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer.

If the Member elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses.

Coverage for reconstructive breast surgery will not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the Plan definition of "Medically Necessary." Benefits will be payable on the same basis as any other Illness or Injury under the Plan.

Treatment for Temporomandibular Joint Dysfunction (TMJ)

Medical services for TMJ are covered on the same basis as any other medical condition. Dental services (i.e. dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums), or orthodontic services (i.e. braces and other orthodontic appliances) are not covered by this Plan for any diagnosis, including TMJ.

External Prosthetic Appliances and Devices

This Plan provides benefits for Covered Expenses made or ordered by a Physician for the initial purchase and fitting of external Prosthetic Appliances and Devices available only by prescription which are Medically Necessary for the alleviation or correction of Illness, Injury, or congenital defect.

External Prosthetic Appliances and Devices include Prostheses/Prosthetic Appliances and Devices; Orthoses and Orthotic Devices; Wigs; Braces; and Splints.

Coverage for external Prosthetic Appliances and Devices is limited to the most appropriate and cost-effective alternative. This includes coverage for repair, maintenance or replacement of a covered Prosthetic Appliance or Device, unless replacement is required because of misuse or loss of the Prosthetic on the part of the Member.

Coverage is provided for custom foot Orthoses and other Orthoses.

- Only the following non-foot Orthoses are covered, when Medically Necessary:
    - Rigid and semi-rigid custom fabricated Orthoses;
    - Semi-rigid prefabricated and flexible Orthoses; and
    - Rigid prefabricated Orthoses, including preparation, fitting and basic additions, such as bars and joints; and
    - A shoe with or without an internally seamless toe.
    - Orthopedic shoes when joined to Braces.
- Custom foot Orthotics are only covered when Medically Necessary, as follows:
    - For Members 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 it 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. amputation) and is necessary for the alleviation or correction of Illness, Injury, or congenital defect; and
    - For Members with a neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot, and there is reasonable expectation of improvement.

Coverage for replacement of external Prosthetic Appliances and Devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the Member will not be covered; and
- Replacement will be provided when anatomic change has rendered the external Prosthetic Appliance or Device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Clinical Trials

Benefits are payable for all routine patient care costs related to an approved clinical trial provided by a Provider, including Phases I through IV, for a Member who meets the following requirements:

- is eligible to participate in an approved clinical trial according to the trial protocol with respect to the prevention, detection and treatment of cancer or other life-threatening disease or condition and
- Either—

- the referring health care professional is a participating health care Provider and has concluded that the Member's participation in such trial would be appropriate based upon the Member meeting the conditions described in paragraph (1); or
- the Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate based upon the Member meeting the conditions described in paragraph (1).

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

The clinical trial must meet one of the following requirements:

1. Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials:

- An institute or center of the National Institutes of Health,
- The Food and Drug Administration,
- The Department of Veterans Affairs,
- The Department of Defense,
- The Department of Energy,
- The Centers for Disease Control and Prevention,
- The Agency for Health Care Research and Quality,
- The Centers for Medicare & Medicaid Services,
- Cooperative group or center of any of the entities described in clauses (i) through (vi) or the Department of Defense or the Department of Veterans Affairs, or
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - Be conducted under an Investigational new drug application reviewed by the Food and Drug Administration; or
    - Involve a drug trial that is exempt from having such an Investigational new drug application; or
    - be approved by a panel of qualified recognized experts in clinical research within academic health institutions in the State of Arizona as part of a scientific study of a new therapy or intervention that is being conducted at an institution in the State of Arizona, that is for the treatment, palliation or prevention of cancer in humans and in which the scientific study includes all of the following: specific goals; a rationale and background for the study; criteria for patient selection; specific directions for administering the therapy and monitoring patients; definition of quantitative measures for determining treatment response; methods for documenting and treating adverse reactions; have been reviewed and approved by an Institutional Review Board of an institution in the State of Arizona; and the personnel providing the treatment or conducting the study at an institution in the State of Arizona agree to accept reimbursement as payment in full from the insurer at the rates that are established by the insurer and that are not more than the level of reimbursement

applicable to other similar services provided by the health care providers in the insurer's network.

For the purposes of the clinical trials conducted by academic health institutions in the State of Arizona, this term shall have the following meaning:

- Institutional Review Board means any board, committee or other group that is both: formally designated by an institution to approve the initiation of and to conduct periodic review of biomedical research involving human subjects and in which the primary purpose of such review is to assure the protection of the rights and welfare of the human subjects and not to review a clinical trial for scientific merit; and approved by the National Institutes of Health Office for Protection From Research Risks.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services typically covered by Cigna Healthcare for a Member who is not enrolled in a clinical trial, including the following:

- Services typically provided absent a clinical trial.
- Services required solely for the provision of the Investigational drug, item, device or service.
- Services required for the clinically appropriate monitoring of the Investigational drug, device, item or service.
- Services provided for the prevention of complications arising from the provision of the Investigational drug, device, item or service.
- Reasonable and necessary care arising from the provision of the Investigational drug, device, item or service, including the diagnosis or treatment of complications.

For clinical trials, routine patient costs **do not** include:

- the Investigational item, device, or service, itself;
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Wellness and Other Program Benefits

Benefits may be available to You and Your Family Members for participating in certain programs that We may make available in connection with this Plan. Such programs may include wellness programs, disease or care management programs. These programs may include a reward or an incentive, which You may earn by completing different activities. You may obtain information regarding the particular programs available at any given time by visiting our website at www.mycigna.com under "Wellness" then select "Wellness and Incentives," or by calling Customer Service at the phone number listed on the back of Your ID card.

Exclusions and Limitations: What Is Not Covered by This Plan

Excluded Services

In addition to any other exclusions and limitations described in this Plan, there are no benefits provided for the following:

1. Any **amounts in excess of maximum benefit limitations of Covered Expenses** stated in this Plan.
2. Services or supplies that are **not Medically Necessary**.
3. Services or supplies that Cigna Healthcare considers to be for **Experimental Procedures or Investigational Procedures or Unproven Procedures.** This does not apply to a Member participating in a Clinical Trial as specifically stated in the sections of this Plan titled "Clinical Trials", "Clinical Trial Costs" and "Off Label Drugs".
4. Services **received before the Effective Date of coverage**.
5. Services **received after coverage under this Plan ends**.
6. Services **for which you have no legal obligation to pay** or for which no charge would be made if you did not have a health plan or insurance coverage.
7. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, **under any workers' compensation, employer's liability law or occupational disease law**, even if the Member does not claim those benefits.
8. Conditions caused by: (a) an **act of war (declared or undeclared)**; (b) the **inadvertent release of nuclear energy** when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Member **participating in the military service of any country**; (d) an Member **participating in an insurrection, rebellion, or riot;** (e) services received as a direct result of an Member's commission of, or attempt to commit a **felony** (whether or not charged) **or as a direct result of the Member being engaged in an illegal occupation; unless an injury for which the plan otherwise provides benefits for treatment is a result of domestic violence or a medical condition;** (f) an Member being intoxicated, as defined by applicable state law in the state where the Illness occurred or under the influence of illegal narcotics or non-prescribed controlled substances unless administered or prescribed by Physician.
9. Any **services provided by a local, state or federal government agency**, except when payment under this Plan is expressly required by federal or state law.
10. Any services required by state or federal law to be supplied by a public school system or school district.
11. Any **services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and military treatment facilities will be considered for payment according to current legislation.
12. **If the Member is enrolled in Medicare** Part A, B, C or D, Cigna Healthcare will provide claim payment according to this Plan minus any amount paid by Medicare, not to exceed the amount Cigna Healthcare would have paid if it were the sole insurance carrier.
13. **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this Plan.

14. Services of a Hospital emergency room **for any condition that is not an Emergency Medical Condition** as defined in this Plan.
15. **Custodial Care, including but not limited to rest cures; infant, child or adult day care, including geriatric day care**.
16. **Private duty nursing** except when provided as part of the home health care services or Hospice Care Services benefit in this Plan.
17. Inpatient room and board **charges in connection with a Hospital stay primarily for environmental change or Physical Therapy.**
18. Services received during **an inpatient stay when the stay is primarily related to** behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of a Mental Health Disorder.
19. **Complementary and alternative medicine services, including but not limited to**: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; meditation; visualization; acupuncture point injection therapy; reflexology; rolfing; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnosis; energy-balancing; breathing exercises; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf; and any other alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. Services specifically listed as covered under "Rehabilitative Therapy" and "Habilitative Therapy" are not subject to this exclusion.
20. Any services or supplies **provided by or at a place for the aged, a nursing home, or any facility** a significant portion of the activities of which include rest, recreation, leisure, or any other services that are not Covered Services.
21. **Assistance in activities of daily living**, including but not limited to bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or convalescent care.
22. **Services performed by unlicensed practitioners** or services which do not require licensure to perform, for example-meditation, breathing exercises, guided visualization.
23. Inpatient room and board **charges in connection with a Hospital stay primarily for diagnostic tests** which could have been performed safely on an outpatient basis.
24. **Services which are self-directed** to a free-standing or Hospital-based diagnostic facility.
25. Services **ordered by a Physician or other Provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility**, when that Physician or other Provider:

    - Has not been actively involved in your medical care prior to ordering the service, or
    - Is not actively involved in your medical care after the service is received.

    This exclusion does not apply to mammography.
26. **Dental services**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Plan.
27. **Dental implants**: dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.

28. **Routine hearing tests** except as provided under Preventive Care.
29. **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Plan under Pediatric Vision Care.
30. An **eye surgery solely for the purpose of correcting refractive defects** of the eye, such as nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia).
31. Outpatient **speech therapy**, except as otherwise stated in this plan.
32. **Cosmetic surgery, therapy** or other services for beautification, to improve or alter appearance or self-esteem or to treat psychological or psychosocial complaints regarding one's appearance. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
33. **Aids or devices that assist with nonverbal communication**, 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 except as specifically stated in this Plan.
34. **Non-medical counseling or ancillary services**, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities and developmental delays, except as otherwise stated in this Plan.
35. Services and procedures for **redundant skin surgery** including abdominoplasty/panniculectomy, removal of skin tags, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; varicose veins; rhinoplasty, blepharoplasty and; orthognathic surgeries**.**
36. Procedures, surgery or treatments to **change characteristics of the body** to those of the opposite sex unless such services are deemed Medically Necessary or otherwise meet applicable coverage requirements.
37. Any treatment, Prescription Drug, service or supply **to treat sexual dysfunction**, enhance sexual performance or increase sexual desire.
38. All services related to **the treatment of fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT)except as specifically stated in this Plan.
39. Charges in connection with elective abortions.
40. 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.
41. Blood administration **for the purpose of general improvement in physical condition.**
42. **Orthopedic shoes** (except when joined to Braces), shoe inserts, foot Orthotic Devices.

43. **External and internal power enhancements** or power controls for Prosthetic limbs and terminal devices.
44. **Myoelectric Prostheses** peripheral nerve stimulators.
45. **Electronic Prosthetic limbs or appliances** unless Medically Necessary, when a less-costly alternative is not sufficient.
46. **Prefabricated foot Orthoses**.
47. **Cranial banding/cranial Orthoses/other similar devices**, except when used postoperatively for synostotic plagiocephaly.
48. **Orthosis shoes**, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers.
49. **Orthoses primarily used for cosmetic** rather than functional reasons.
50. **Non-foot Orthoses**, except **only** the following non-foot Orthoses are covered when Medically Necessary:
    - Rigid and semi-rigid custom fabricated Orthoses;
    - Semi-rigid prefabricated and flexible Orthoses; and
    - Rigid prefabricated Orthoses, including preparation, fitting and basic additions, such as bars and joints.
51. Services primarily for **weight reduction or treatment of obesity including morbid obesity**, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Member has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
52. **Routine physical exams or tests** that do not directly treat an actual Illness, Injury or condition. This includes reports, evaluations, or hospitalization not required for health reasons; physical exams required for or by an employer or for school, or sports physicals, or for insurance or government authority, and court ordered, forensic, or custodial evaluations, except as otherwise specifically stated in this Plan.
53. Therapy or treatment **intended primarily to improve or maintain general physical condition** or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
54. **Educational services** except for Diabetic Self-Management Training Programs, treatment for Autism, or as specifically provided or arranged by Cigna Healthcare.
55. **Nutritional counseling or food supplements**, except as stated in this Plan.
56. **Exercise equipment, comfort items and other medical supplies and equipment** not specifically listed as Covered Services in the "Comprehensive Benefits: What the Plan Pays For" section of this Plan. Excluded medical equipment includes, but is not limited to: air purifiers, air conditioners, humidifiers; treadmills; spas; elevators; supplies for comfort, hygiene or beautification; wigs, disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this Plan.

57. **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the Schedule of Benefits and under "Rehabilitative Therapy Services (Physical Therapy, Occupational Therapy and Speech Therapy)" in the section of this Plan titled "Comprehensive Benefits: What the Plan Pays For."
58. **Foreign Country Provider** charges except as specifically stated under "Foreign Country Providers" in the section of this Plan titled "Comprehensive Benefits: What the Plan Pays For."
59. **Routine foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, a systemic condition, Injury or symptoms involving the feet except as otherwise stated in this Policy.
60. **Charges for which We are unable to determine Our liability** because the Member failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
61. Charges for the **services of a standby Physician**.
62. Charges for **animal to human organ transplants**.
63. **Claims received by Cigna Healthcare after 15 months from the date service was rendered**, except in the event of a legal incapacity.
64. Services obtained from a **Dedicated Virtual Care Physician** that are not Dedicated Virtual Urgent Care or Dedicated Virtual Primary Care services.

Prescription Drug Benefits

Pharmacy Payments

For definitions associated with Prescription Drug benefits, refer to the "Definitions" section of this Plan. Prescription Drug benefits are subject to the provisions within this section, and all other Plan provisions.

Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the Deductible shown in the Schedule of Benefits, and, once the Deductible is satisfied, subject to any applicable Copayments and/or Coinsurance shown in the Schedule of Benefits. For additional information on the Deductible, please refer to the "Definitions" section of the Plan.

Cigna Healthcare's Prescription Drug List is available upon request by calling Customer Service at the phone number listed on the back of Your ID card or at www.cigna.com/ifp-drug-lists.

In the event that you request a Brand Name Drug that has a Generic equivalent, you will be financially responsible for the amount by which the cost of the Brand Name Drug exceeds the cost of the Generic Drug, plus the Brand Copayment or Coinsurance shown in the Schedule of Benefits.

Your responsibility for covered Prescription Drugs and Related Supplies will always be the lowest of:

- the Copayment or Coinsurance for the Prescription Drug; or
- Cigna Healthcare's discounted rate for the Prescription Drug; or
- the Pharmacy's Usual and Customary (U&C) charge for the Prescription Drug.
- Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers, regardless of the customer's payment source.

Coupons, Incentives and Other Communications

Manufacturer coupons or any other payments made on Your behalf will be counted toward any applicable Deductible, Cost Share or Maximum Out of Pocket, for covered Brand Name Drugs that do not have a Generic equivalent or drugs obtained through Prior Authorization, Step Therapy or an exceptions and appeals process covered under this Agreement.

Cigna Healthcare's Specialty Pharmacy

Accredo, Cigna Healthcare's specialty Pharmacy, is available to fill and ship Specialty Medications used to treat complex conditions. Accredo's team of specialty-trained pharmacists and nurses provide personalized care and support to manage your therapy.

When you use Cigna Healthcare's specialty Pharmacy for your Specialty Medications, you receive personalized care and support such as: 24/7 access to pharmacists and nurses with experience

and training in complex conditions, counseling, help managing side effects and one-on-one guidance from a clinician on how to administer your Specialty Medication. Some Specialty Medications may be eligible for copay assistance programs for which a dedicated team can assist you. The specialty Pharmacy also allows you several choices on how you want to connect with them – by text, phone and/or online resources.

The specialty Pharmacy makes it convenient for you to get your Specialty Medications by working with your Physician to obtain Prior Authorization, if required. They also schedule and ship your Specialty Medications quickly and with special handling, such as refrigeration. All necessary supplies, such as syringes or a sharps container, are also included at no extra cost.

To make sure you don't miss any doses of your Specialty Medication they will send you refill reminders and real-time updates once your medication has shipped.

You or your Physician can call Accredo, Cigna Healthcare's specialty Pharmacy, at 877-826-7657 to talk with a representative.

Prescription Drugs Covered under the Medical Benefits

When Prescription Drugs on Cigna Healthcare's Prescription Drug List or on the Cigna Pathwell Specialty Medication Drug List are administered in a health care setting by a Physician or Other Health Care Professional, and are billed with the office or facility charges, they will be covered under the medical benefits of this Plan. These medications may still be subject to Prior Authorization or Step Therapy requirements.

Limited Distribution Drugs

For certain Limited Distribution Drugs covered under the medical benefits of this Plan, the Provider who administers the drug must obtain the drug directly from Accredo, Cigna Healthcare's preferred specialty Pharmacy, or if not available through Accredo then through a network specialty Pharmacy, in order for that drug to be covered. If you have questions about where your Provider obtained the drugs being administered to you, please consult your Provider.

Specialty Medications that require administration through the Cigna Pathwell Specialty Network

Certain Specialty Medications often used for the treatment of complex conditions that are high cost, require special handling and administration, Provider coordination, or patient education may be subject to additional coverage criteria or require administration by a Participating Provider in the Cigna Pathwell Specialty Network. Cigna determines which injections, infusions, and implantable drugs are subject to these criteria and requirements.

A complete list of these Specialty Medications subject to additional coverage criteria or that require administration by a Participating Provider in the Cigna Pathwell Specialty Network is available at www.cigna.com/pathwellspecialty.

The following are not covered, unless a medical necessity coverage exception is obtained:

- Specialty Medication regimens that have a therapeutic equivalent or therapeutic alternative to another covered Prescription Drug(s);

- Specialty Medications newly approved by the Food and Drug Administration (FDA) up to the first 180 days following its market launch;
- Specialty Medication regimens for which there is an appropriate lower cost alternative for treatment.

Cigna may consider certain Specialty Medication regimens as preferred when they are clinically superior to alternative treatments and more cost effective. Preferred regimens may be required for coverage, except when the Member is not a candidate for the regimen and a medical necessity coverage exception is obtained.

Certain Specialty Medications may be covered only under the Prescription Drug benefits of this Plan when one or more of the following criteria is met:

- Cost of the medication is lower under Pharmacy sources than medical sources in the Cigna Pathwell Specialty Network;
- Provider accepts the medication from the Pharmacy source;
- The Member is able to self-administer the medication procured from a Pharmacy.

Self-Administered Injectable Medication and Infusion and Injectable Medication Benefits

Drugs Covered under the Prescription Drug Benefits

Self-administered Injectable Medications, and syringes for the self-administration of those drugs, on Cigna Healthcare's Prescription Drug List are covered under the Prescription Drug benefits of this Plan. To determine if a drug prescribed for you is covered, you can:

- log on to your www.mycigna.com account, and
- view the Cigna Healthcare Prescription Drug List at www.cigna.com/ifp-drug-lists, and
- then choose the Cigna Healthcare Prescription Drug List for your state.

Note: the drugs may be subject to Prescription Drug Prior Authorization or Step Therapy requirements.

Medications Covered under the Medical Benefits

Infusion and Injectable Medications on Cigna Healthcare’s Prescription Drug List are covered under the medical benefits of this Plan when they are administered in a healthcare setting by a Physician or Other Health Care Professional and are billed with the office or facility charges.

You or your Physician can view the Cigna Healthcare Prescription Drug List by:

- accessing www.cigna.com/ifp-drug-lists, and
- choose your state.

Note: the drugs may be subject to Prescription Drug Prior Authorization or Step Therapy requirements.

Split Fill Dispensing Program

This program applies for the first 30 days when you start a new therapy on certain Limited Distribution Drugs and Specialty Medications. The split fill dispensing program is designed to

prevent wasted Prescription Drugs if your Prescription Drug or dose changes. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions. You will initially get up to a 15-day supply of your Prescription Order for certain drugs filled at Accredo or Express Scripts, Our home delivery Pharmacy instead of the full Prescription Order. You pay half the 30-day Cost Share for this initial 15-day supply and would be responsible for the other half of the 30-day Cost Share if an additional 15-day supply is provided. The therapeutic classes of Prescription Drugs that are included in this program are determined by Cigna Healthcare and will be managed for continuation in this program as new clinical guidelines and dispensing experience dictates.

Prescription Drug List Management

The Prescription Drug List is managed by the Health Plan Value Assessment Committee (HVAC), which makes, subject to the P&T Committee's review and approval of the Prescription Drug List, coverage tier placement decisions of Prescription Drugs or Related Supplies and/or applies utilization management requirements to certain Prescription Drugs or Related Supplies. Your Plan's coverage tiers may contain Prescription Drugs or Related Supplies that are Generic Drugs, Brand Name Drugs or Specialty Medications. Placement of any Prescription Drug or Related Supplies in a specific tier, and application of utilization management requirements to a Prescription Drug, depends on a number of clinical and economic factors. Clinical factors include, without limitation, the P&T Committee's evaluations of the place in therapy, or relative safety or relative efficacy of the Prescription Drug or Related Supplies, and economic factors include, without limitation, the cost and/or available rebates for Prescription Drugs or Related Supplies. Whether a particular Prescription Drug or Related Supply is appropriate for You or any of Your Family Member(s), regardless of its eligibility coverage under Your Plan, is a determination that is made by You (or Your Family Member) and the prescribing Physician.

The coverage status of a Prescription Drug or Related Supply may change periodically during the Plan Year for various reasons. For example, a Prescription Drug or Related Supply may be removed from the market, a new Prescription Drug in the same therapeutic class may become available, or the cost of a Prescription Drug or Related Supply may increase.

As a result of coverage changes, you may be required to pay more or less for that Prescription Drug or Related Supply or try another covered Prescription Drug or Related Supply. Please access www.mycigna.com through the Internet or call Customer Service at the phone number listed on the back of Your ID card for the most up-to-date coverage tier status, utilization management, or other coverage limitations for Prescription Drugs or Related Supplies.

Off-Label Cancer Drug that has been prescribed for a specific type of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration (U.S. FDA). However, such drugs will be covered if: the drug is recognized as safe and effective for treatment of the specific type of cancer in one of the standard medical reference compendia or in medical literature; and the drug has not been determined by the FDA to be contraindicated for the specific type of cancer being treated. Coverage includes covered Medically Necessary services associated with the administration of the prescription drug.

Covered Expenses

If a Member, while covered under this Plan, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna Healthcare will provide coverage for those expenses as shown in the Schedule of Benefits.

Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a Prescription issued to You or Your Family Members by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When You or Your Family Members are issued a Prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that Prescription cannot reasonably be filled by a Participating Pharmacy, the Prescription will be covered by Cigna Healthcare as if filled by a Participating Pharmacy.

Patient Assurance Program

Your Plan offers additional discounts for certain covered Prescription Drugs that are dispensed by a Pharmacy included in what is known as the "Patient Assurance Program." As may be described elsewhere in this Plan, from time-to-time Cigna Healthcare may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your out-of-pocket expenses for certain covered Prescription Drugs for which Cigna Healthcare directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna Healthcare for certain covered Prescription Drugs included in the Patient Assurance Program is applied or credited to a portion of your Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drugs as set forth in the Schedule of Benefits may be reduced in order for Patient Assurance Program discounts or other payments earned by Cigna Healthcare to be applied or credited to the Copayment or Coinsurance, if any, as described above.

For example, certain insulin drugs covered under the Prescription Drug benefit for which Cigna Healthcare directly or indirectly earns a discount in connection with the Patient Assurance Program may result in a credit toward some or all of your Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in the Schedule of Benefits, for the insulin drugs. In addition, the covered insulin drugs eligible for Patient Assurance Program discounts may not be subject to a Deductible, if any.

Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drugs under the Patient Assurance Program applies toward your Out-of-Pocket Maximum.

Please note that the Patient Assurance Program discounts that Cigna Healthcare may earn for Prescription Drugs and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any rebates or other payments that Cigna Healthcare may earn from a pharmaceutical manufacturer for the same or other Prescription Drugs. Except as may be noted elsewhere in this Plan, you are not entitled to the benefit of those rebates or other payments earned by Cigna Healthcare because they are unrelated to the Patient Assurance Program. Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drugs included in the Patient Assurance Program and/or your Copayment or Coinsurance, if any for those eligible Prescription Drugs, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to Cigna Healthcare in connection with the Patient Assurance Program. More information about the Patient Assurance Program, including the Prescription Drugs included in the program, is available at the website shown on your ID card or by calling Customer Service at the phone number listed on the back of Your ID card.

What Is Covered

- Outpatient drugs and medications that federal and/or applicable state law restrict to sale by Prescription only, except for insulin which does not require a Prescription.
- Pharmaceuticals to aid smoking cessation in accordance with “A” or “B” recommendations of the U.S. Preventive Services Task Force.
- Insulin (no Prescription required); syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; oral hypoglycemic agents; Glucagon Emergency Kits and alcohol swabs.
- Orally administered and self-injected anti-cancer medications prescribed in connection with cancer chemotherapy treatments.
- All non-infused compound Prescription Drugs that contain at least one FDA-approved Prescription ingredient compounded from an FDA-approved finished pharmaceutical product and are otherwise covered under the Pharmacy benefits, excluding any bulk powders included in the compound.
- Contraceptive drugs and devices approved by the FDA.
- Specialty Medications.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, when available for administration at a Pharmacy.

Conditions of Service

The drug or medicine must be all of the following:

- Prescribed in writing, except for insulin, by a Physician and dispensed within one year of being prescribed, subject to federal or state laws.
- Approved for use by the Food and Drug Administration.
- For the direct care and treatment of the Member’s Illness, Injury or condition; however dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Physician for the care and treatment of a Member’s Illness.
- Purchased from a licensed retail Pharmacy or ordered by mail through Express Scripts Pharmacy, Cigna Healthcare’s home delivery Pharmacy.
- The drug or medicine must not be used while the Member is an inpatient in any facility.
- The Prescription must not exceed the days’ supply indicated in the “Limitations” section below.
- Infusion and Injectable Medications and Specialty Medications may require Prior Authorization or Step Therapy.

Exclusions

The following are not covered under this Plan. No payment will be made for the following expenses:

1. Drugs not approved by the Food and Drug Administration;
2. Any drugs that are not on the Prescription Drug List and not otherwise approved for coverage through the non-Prescription Drug List exception process;
3. Drugs, devices and/or supplies available over the counter that do not require a Prescription by federal or state law except as otherwise stated in this Plan, or specifically designated as No Cost Preventive Care and required by the Patient Protection and Affordable Care Act (PPACA);
4. Drugs that do not require a federal legend (a federal designation for drugs requiring supervision of a Physician), other than insulin;
5. Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
6. 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;
7. Any injectable drugs that require Physician supervision and are not typically considered self-administered drugs are covered under the medical benefits of this Plan and require Prior Authorization. The following are examples of Physician supervised drugs: injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables, and endocrine and metabolic agents;
8. Infertility related drugs, except those required by the Patient Protection and Affordable Care Act (PPACA)
9. Infused immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions are covered under the medical benefits, in the Covered Expenses sectionof this Plan;
10. Any drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido and/or sexual desire;
11. Any drugs used for weight loss, weight management, metabolic syndrome, and antiobesity agents;
12. Any drugs that are Experimental or Investigational or Unproven as described in this Plan; except as specifically stated in the sections of this Plan titled “Clinical Trials” and any benefit language concerning “Off Label Drugs”;
13. Food and Drug Administration FDA-approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (the American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language biomedical journals;
14. Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies, except for those pertaining to Diabetic Supplies and Equipment;

15. Prescription vitamins other than prenatal vitamins, dietary supplements, herbal supplements and fluoride other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);
16. Drugs used for cosmetic purposes that have no medically acceptable use, such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
17. Medications used for travel prophylaxis, except anti-malarial drugs;
18. Drugs obtained outside the United States;
19. Any fill or refill of Prescription Drugs and Related Supplies to replace those lost, stolen, spilled, spoiled or damaged before the next refill date;
20. Drugs used to enhance athletic performance;
21. Drugs which are to be taken by or administered to the Member while 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;
22. Any Drugs, medications, or other substances dispensed or administered in any outpatient setting. This includes, but is not limited to, items dispensed by a Physician;
23. Drug convenience kits;
24. Prescriptions more than one year from the original date of issue;
25. Any costs related to the mailing, sending or delivery of Prescription Drugs;
26. Any intentional misuse of this benefit, including Prescription Drugs and Related Supplies purchased for consumption by someone other than the Member.

Limitations

Each Prescription Order or refill, unless limited by the drug manufacturer's packaging, shall be limited as follows:

- Up to a 90-day supply, at a retail Participating Pharmacy for drug tiers 1 through 4 and up to a 30-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers please refer to the Schedule of Benefits).
- Up to a 90-day supply, at a 90 Day Retail Pharmacy for drug tiers 1 through 4 and up to a 90-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging. To locate a 90 Day Retail Pharmacy you can call customer service at the phone number listed on the back of Your ID card or go to www.cigna.com/ifp-providers (for detailed information about drug tiers please refer to the Schedule of Benefits).
- Up to a 90-day supply at Express Scripts Pharmacy, Cigna Healthcare's home delivery Pharmacy for drug tiers 1 through 4 and up to a 30-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers please refer to the Schedule of Benefits).
- Tobacco cessation medications that are included on Cigna Healthcare's Prescription Drug List are limited to two 90-day supplies per Plan Year.

- Managed drug limits (MDL) may apply to dose and/or number of days' supply of certain drugs; managed drug limits are based on recommendations of the federal Food and Drug Administration (FDA) and the drug manufacturer.
- To a dosage and/or dispensing limit as determined by the P&T Committee.

Medication Synchronization

Medication Synchronization means the coordination of medication refills for a patient taking two or more medications for a chronic condition that are being dispensed by a single Network Pharmacy to facilitate the synchronization of the patient's medications for the purpose of improving medication adherence. This plan will prorate the cost sharing rate for a Prescription Drug Product that is dispensed for less than the standard refill amount if the insured requests:

- enrollment into a Medication Synchronization program; and
- less than the standard refill amount for the purpose of synchronizing the insured's medications.

Prescription Eye Drops

Refills for prescription eye drops to treat glaucoma or ocular hypertension will be provided if all of the following apply:

- the insured requests the refill:
- for a thirty-day supply, at least twenty-three days and less than thirty days from the later of:
- the original date that the prescription was distributed to the insured.
- the date of the most recent refill that was distributed to the insured.
- for a sixty-day supply, at least forty-five days and less than sixty days from the later of:
- the original date that the prescription was distributed to the insured.
- the date of the most recent refill that was distributed to the insured.
- for a ninety-day supply, at least sixty-eight days and less than ninety days from the later of:
- the original date that the prescription was distributed to the insured.
- the date of the most recent refill that was distributed to the insured.
- the prescription eye drops to treat glaucoma or ocular hypertension prescribed by the health care provider are a covered benefit under the insured's plan.
- the prescribing health care provider indicates on the original prescription that additional quantities of the prescription eye drops to treat glaucoma or ocular hypertension are needed.
- the refill requested by the insured does not exceed the number of additional quantities prescribed.

Supplemental Drug Discount Program

You are responsible for paying 100% of the cost for any Prescription Drugs or Related Supplies excluded by this plan. However, the Supplemental Drug Discount Program allows Participating Pharmacies to charge You and Your Family Member(s) the discounted cost of non-covered Prescription Drugs and Related Supplies. This means you will pay 100% of the discounted cost, rather than the full cost, of Prescription Drugs and Related Supplies the plan does not cover.

Please note: the out-of-pocket costs that You and Your Family Member(s) pay for any Prescription Drugs or Related Supplies the plan does not cover will not be applied to the Member's Deductible or Out-of-Pocket Maximum.

Authorization, Exception and Appeal Process for Prescription Drugs and Related Supplies

Authorization from Cigna Healthcare is required for certain Prescription Drugs and Related Supplies, meaning that your Physician must obtain Authorization from Cigna Healthcare before the Prescription Drug or Related Supply will be covered.

Prior Authorization
When your Physician prescribes certain Prescription Drugs or Related Supplies, including high cost and Specialty Medications, Cigna Healthcare requires your Physician to obtain Authorization before the Prescription or supply can be filled. To obtain Prior Authorization, your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

Step Therapy
Step Therapy is a type of Prior Authorization. Cigna Healthcare may require a Member to follow certain steps before covering some Prescription Drugs and Related Supplies, including without limitation, some higher-cost and Specialty Medications. If a Prescription Drug or Related Supply is subject to a Step Therapy requirement, then you must try one or more similar Prescription Drugs and Related Supplies before the Plan will cover the requested Prescription Drug or Related Supply. The Prescription Drugs and Related Supplies that require Step Therapy can be identified on the Prescription Drug List at www.mycigna.com. To obtain Step Therapy Authorization, your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

Exceptions for Prescription Drugs and Related Supplies Not on the Prescription Drug List
If your Physician prescribes a Prescription Drug or Related Supply that is not on Cigna Healthcare's Prescription Drug List, he or she can request that Cigna Healthcare make an exception and agree to cover that drug or supply for your condition. To obtain an exception for a Prescription Drug or Related Supply, your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

Prescription Drug and Related Supply Authorization and Exception Request Process
To obtain an exception, your Physician may call Cigna Healthcare, or complete the appropriate form and fax it to Cigna Healthcare to request an exception. Your Physician can certify in writing that you have previously used a Prescription Drug or Related Supply that is on Cigna Healthcare's Prescription Drug List or in a Step Therapy Protocol, and the Prescription Drug or Related Supply has been detrimental to your health or has been ineffective in treating your condition and, in the opinion of your Physician, is likely to again be detrimental to your health or ineffective in treating the condition. The exception request will be reviewed and completed by Cigna Healthcare within 72 hours of receipt.

Expedited Review of a Prior Authorization, Step Therapy or Prescription Drug Exception Request
An expedited review may be requested by your Physician when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a Prescription Drug or Related

Supply not on Cigna Healthcare's Prescription Drug List. The expedited review will be reviewed and completed by Cigna Healthcare within 24 hours of receipt.

If the request is approved, your Physician will receive confirmation. The Authorization/Exception will be processed in Cigna Healthcare's pharmacy claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the Authorization will be granted until you no longer use the Prescription Drug or Related Supply for which the Authorization or Exception was approved. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the Prescription(s).

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

Appeal of a Prior Authorization, Step Therapy or Prescription Drug Exception Denial
If you, a person acting on your behalf or the prescribing Physician or other prescriber disagree with a coverage decision, you, a person acting on your behalf or the prescribing Physician or other prescriber may appeal that decision in accordance with the provisions of this Plan, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered. Please see the section of this Plan entitled "When You Have a Complaint or an Appeal" which describes the process for the external independent review.

If you have questions about specific Prescription Drug List exceptions, Prior Authorization or a Step Therapy request, call Customer Service at the phone number listed on the back of Your ID card.

Coverage of New Drugs

All new FDA-approved Prescription Drugs or Related Supplies (or new FDA-approved indications) are designated as non-Prescription Drug List Prescription Drugs or Related Supplies until the Cigna Health Plan Value Assessment Committee (HVAC) makes a placement decision on the new Prescription Drug or Related Supply (or new indication), which decision shall be based in part on the P&T Committee's clinical review of the drug. The P&T Committee makes a reasonable effort to review all new FDA-approved Prescription Drugs or Related Supplies (or new FDA-approved indications) within 90 days of its release to the market. The Health Plan Value Assessment Committee (HVAC) must make a decision on each new FDA-approved drug product (or new FDA-approved indication) within 180 days of its release onto the market, or a clinical justification must be documented if this timeframe is not met.

Reimbursement/Filing a Claim

When a Member purchases Prescription Drugs or Related Supplies through a retail Participating Pharmacy they pay any applicable Copayment, Coinsurance or Deductible shown in the Schedule of Benefits at the time of purchase. The Member does not need to file a claim form.

To purchase Prescription Drugs or Related Supplies from Express Scripts Pharmacy, Cigna Healthcare's home delivery Pharmacy, see the home delivery drug brochure at www.mycigna.com, or call t Customer Service at the phone number listed on the back of Your ID card.

Claims and Customer Service

Drug claim forms are available upon written request to:

For retail Pharmacy claims:
Cigna Healthcare Pharmacy Service Center
PO Box 188053
Chattanooga TN 37422-8053

For home delivery Pharmacy claims:
Express Scripts Pharmacy
PO Box 66301
St Louis MO 66301-6301
1-800-835-3784

Forms are also available online at www.mycigna.com.

The address to which you must mail paper claim forms is subject to change. Please check www.mycigna.com or call Customer Service at the phone number listed on the back of Your ID card to confirm the appropriate mailing address for any claim form you wish to send. If You or Your Family Member(s) have any questions about the Prescription Drug benefit, call the toll-free customer service number on the back of your ID card**.**

Pediatric Dental Care

For Members up to age 19, We cover medically necessary dental services including Diagnostic services, preventive services, restorative services, adjunctive services, implants, and orthodontics, as determined by the standards of generally accepted dental practice. The dental benefits only apply to Members until the end of the month in which the Member turns nineteen (19) of age.

We cover the Dental Services below, when they are performed by an In-Network Provider (licensed Dentist and when they are necessary and customary, as determined by the standards of generally accepted dental practice. We also cover Dental Services below performed by Out-of-Network Dentists, which are not contracted with Us and can Balance Bill You for the difference between their actual charges and the usual and customary rate We reimburse for that specific dental procedure. The usual and customary rate is deemed customary within the range of charges made for the same service or supply by other Providers of similar training or experience in that general geographic area. We will reimburse a portion of the usual and customary rate for services by Out-of-Network Providers, but You will be responsible for paying the entire balance between what the Out-of-Network Provider actually charges (which could be much higher than the usual and customary rate) and what We reimburse. To ensure that You do not receive any additional charges, please visit an In-Network Dentist. The frequency of services performed In-Network and Out- of-Network cross accumulate.
If there is more than one professionally acceptable treatment for Your dental condition, the Plan will cover the least expensive treatment.

Dental Necessity or Dentally Necessary: Covered services which are necessary and appropriate for the treatment of the teeth, gums, and supporting structures and that are (a) provided according to professionally recognized standards or practice; (b) determined to be consistent with the dental condition, and (c) are the most appropriate type, supply and level of service considering the potential risks, benefits, and covered services which are alternatives. The covered procedures, services, frequency limitations, and exclusions listed in this Certificate are compliant with the benchmark pediatric dental plan of the State of Arizona. Additional requests, beyond the stated frequency limitations shall be considered when documented dental necessity is justified due to a physical limitation and/or an oral condition that prevents daily hygiene. If a Member receives a service listed in Section, Pediatric Dental Exclusions or if the Member exceeds the Benefit Limit, the Member will be financially responsible for all charges or fees associated with the service.

Predetermination of Benefits
Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, Cigna will determine covered dental expenses when it receives a claim.
Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $500.

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Pediatric Dental Covered Services.
We cover five categories of dentally necessary pediatric dental services, Diagnostic and Preventive, Restorative, Major, Medically Necessary Orthodontics and emergency treatment, with all services subject to annual limitations. Each is subject to a different cost-share as noted in the Schedule of Benefits.

Covered Services

The following section lists covered dental services; if a service is not listed there is no coverage:

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period

D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
D0391	Interpretation of Diagnostic Image	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).
D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	2 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**

D1510	Space maintainer - fixed - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1516	Space maintainer - fixed – bilateral, maxillary	Non-orthodontic treatment for prematurely removed or missing teeth.
D1517	Space maintainer - fixed – bilateral, mandibular	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1526	Space maintainer - removable – bilateral, maxillary	Non-orthodontic treatment for prematurely removed or missing teeth.
D1527	Space maintainer - removable – bilateral, mandibular	Non-orthodontic treatment for prematurely removed or missing teeth.
D1551	Re-cementation of space maintainer, maxillary	Non-orthodontic treatment for prematurely removed or missing teeth.
D1552	Re-cementation of space maintainer, mandibular	Non-orthodontic treatment for prematurely removed or missing teeth.
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	Non-orthodontic treatment for prematurely removed or missing teeth.
D1556	Removal of fixed unilateral space maintainer - per quadrant	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2929	Prefabricated porcelain crown - primary	1 per tooth in 60 months
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**

D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
D2976	Band stabilization – per tooth	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
D7921	Collect – Apply Autologous Product	1 every 36 months
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**

D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5511	Repair broken complete denture base, mandibular	
D5512	Repair broken complete denture base, maxillary	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5611	Repair resin denture base, mandibular	
D5612	Repair resin denture base, maxillary	
D5621	Repair cast framework, mandibular	
D5622	Repair cast framework, maxillary	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	

D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	
OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
D7953	Bone replacement graft for ridge preservation – per site	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2610	Inlay–porcelain/ceramic–one surface	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2620	Inlay– porcelain/ceramic–two surfaces	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2630	Inlay– porcelain/ceramic–three or more surfaces	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2642	Onlay– porcelain/ceramic–two surfaces	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2643	Onlay– porcelain/ceramic–three surfaces	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.

D2644	Onlay– porcelain/ceramic–four or more surfaces	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.

D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
D2981	Inlay Repair	
D2982	Onlay Repair	
D2983	Veneer Repair	
D2990	Resin infiltration/smooth surface	1 in 36 months
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	
ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**

D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification/pulpal regeneration - INTERIM medication replacement	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3355	Pulpal regeneration - initial visit includes opening tooth, preparation of canal Spaces, placement of medication	
D3356	Pulpal regeneration - interim medication replacement	
D3357	Pulpal regeneration - completion of treatment - does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4212	Gingivectomy or gingivoplasty – with restorative procedures, per tooth	1 every 36 months

D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4241	Gingival flap procedure, including root planning – one to three contiguous teeth or tooth bounded spaces per quadrant	1 every 36 months
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4261	Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant	1 every 36 months
D4263	Bone replacement graft – first site in quadrant	1 every 36 months
D4270	Pedicle soft tissue graft procedure	
D4273	Subepithelial connective tissue graft procedures, per tooth	
D4275	Soft tissue allograft	1 every 36 months
D4277	Free soft tissue graft – 1st tooth	
D4278	Free soft tissue graft – additional teeth	
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**

D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5284	Removable unilateral partial denture - one piece flex base (includes retentive/clasp materials, rest & teeth) per quad	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5286	Removable unilateral partial denture - one piece resin (include retentive/clasp material, rests & teeth) per quadrant	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of INTERIM implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,

D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	
D6111	Implant /abutment supported removable denture for edentulous arch - mandibular	
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	
D6113	Implant /abutment supported removable denture for partially edentulous arch - mandibular	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,
D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6057	Custom Abutment	1 every 60 months
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be

		repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be

		repaired
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6115	Implant /abutment supported fixed denture for edentulous arch - mandibular	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6116	Implant/abutment supported fixed denture for partially edentulous arch maxillary	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6117	Implant /abutment supported fixed denture for partially edentulous arch - mandibular	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular - Used when a period of healing is necessary prior to fabrication and placement of a permanent prosthetic	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary - Used when a period of healing is necessary prior to fabrication and placement of a permanent prosthetic	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6100	Implant removal, by report	1 per 60 consecutive month period,
D6101	Debrideemnt periimplant defect, covered if implants are covered	1 every 60 months

D6102	Debridement and osseous periimplant defect, covered if implants are covered	1 every 60 months
D6103	Bone graft periimplant defect, covered if implants are covered	
D6104	Bone graft implant replacement, covered if implants are covered	
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the

		previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not

		serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**

D9222	Deep sedation/general anesthesia - first 15 minutes	
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	
D9239	Intravenous conscious sedation/analgesia - first 15 minutes	
D9243	Intravenous conscious sedation/analgesia - each subsequent 15 minute increment	
CONSULTATIONS		
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	
MEDICATIONS		
D9610	Therapeutic drug injection, by report	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9944	Occlusal guard – hard appliance, full Arch Removable dental appliance designed to minimize the effects of bruxism or other Occlusal factors. Not to be reported for any Type of sleep apnea, snoring or TMD appliances.	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**
D9945	Occlusal guard – soft appliance, full Arch Removable dental appliance designed to minimize the effects of bruxism or other Occlusal factors. Not to be reported for any Type of sleep apnea, snoring or TMD appliances.	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**
D9946	Occlusal guard – hard appliance, partial Arch Removable dental appliance designed to minimize the effects of bruxism or other Occlusal factors. Provides only partial Occlusal coverage such as anterior Deprogrammer. Not to be reported for any Type of sleep apnea, snoring or TMD appliances.	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
D8090	Comprehensive orthodontic treatment of adult dentition	
D8091	Comprehensive orthodontic treatment with orthognathic surgery	
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Exclusions and Limitations: What Is Not Covered

Excluded Services

Covered Expenses do not include expenses incurred for:

- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary.
- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment, except in cases where it is Dentally Necessary
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time or transportation costs.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

- For services or supplies that are not Dentally Necessary.
- For services received before the Effective Date of coverage.
- For services received after coverage under this Policy ends.
- For services for which You have no legal obligation to pay or for which no charge would be made if You did not have dental insurance coverage.
- For Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Dentist, from any of the following:
    - Yourself or Your employer;
    - a person who lives in the Insured Person's home, except for Family Members, or that person’s employer;
- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;

- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- Procedures that are a covered expense under any other dental plan which provides dental benefits
- Any services covered under both a medical plan and this dental plan and reimbursed under the medical plan will not be reimbursed under this Plan.
- To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a “no-fault” insurance law or an uninsured motorist insurance law. Cigna will take into account any adjustment option chosen under such part by you or any one of your Dependents

Please submit appeals regarding Your dental coverage for Members under 19 years of age to the following address:

Cigna Health and Life Insurance Company
Appeals and Grievances
PO Box 188062
Chattanooga, TN 37422-8062

Pediatric Vision Care

Please be aware that the Pediatric Vision network is different from the network of Your medical benefits.

Covered Pediatric Vision Benefits are subject to any applicable Coinsurance shown in the Schedule of Benefits, where applicable.

Benefits will apply until the end of the month in which the limiting age is reached.
Note: Routine vision screening performed by a PCP or pediatrician is covered under the preventive services benefit.

Covered Benefits

Covered Benefits for Members, through the end of the month in which the Member turns 19 years of age, include:

- Examinations – One vision and eye health evaluation per Plan Year by an Optometrist or an Ophthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.

- Eyeglass lenses include all prescription including prism, choice of polycarbonate, glass or plastic standard single vision, lined bifocal, lined trifocal, lenticular and standard progressive lenses: including these additional lens add-ons:
  - Oversize lenses;
  - All Solid and gradient tints;
  - Scratch-coating;
  - Ultra-Violet (UV) coating;
  - Additional Photochromic Glass or Plastic (i.e. Transitions);
  - Minimum 20% savings* on all additional lens enhancements you choose for your lenses, including but not limited to: anti-reflective coatings; photochromic (glass or plastic); polarized; hi-index and lens styles such as blended segment, intermediate, and premium progressive lenses.

* Provider participation is 100% voluntary; please check with your eye care professional for any offered discounts.

- Frames – One frame for prescription lenses per Plan Year from pediatric frame collection. Only frames in the pediatric frame collection are covered at 100%; there is a one-year manufacturer warranty for standard frames. The Cost Share for non-covered frames is up to 80% of retail.

- Elective Contact Lenses– One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same Plan Year), including the professional services.
- Therapeutic Contact Lenses are covered for a one year supply, regardless of the contact lens type, including professional services, in lieu of frame and lenses. Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by Your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction are not covered.
- Low Vision Coverage: Supplemental professional low vision services and aids are covered in full once every 12 months for an Insured Person with partial sight, or whose sight is not fully

correctable with surgery, pharmaceuticals, contact lenses or glasses. There are various low vision aids, such as high- powered spectacles, magnifiers and telescopes, which can aid the Insured Person with their specific needs.

Some Cigna Vision Network eye care professionals may not offer these services. Please check with Your eye care professional first before scheduling an appointment.

Exclusions

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges incurred after the Policy ends or the Insured's coverage under the Plan ends, except as stated in the Certificate.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "Covered Benefits" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lenses, treatments, "add ons", or lens coatings not otherwise listed in "Covered Benefits." within this section, above.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- For or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
- Claims submitted and received in-excess of twelve-(12) months from the original Date of Service, except in the event of legal incapacity or as required by law.

Cigna Vision Providers

To find a Cigna Vision Provider, or to get a claim form, the Insured Person should visit **www.mycigna.com** and use the link on the vision coverage page, or they may call Customer Service using the toll-free number on their identification card.

General Provisions

Third Party Liability

You agree to advise Us, in writing, within a reasonable time of your claim against the third party and to take such action, provide such information and assistance, and execute such documents as We may reasonably require to facilitate enforcement of the claim. You also agree to take no action that may prejudice the rights or interests of Us under this Plan. Failure to provide notice of a claim or to cooperate with Us, or actions that prejudice our rights or interests, may be considered to be a material breach by Us and may subject you to legal action.

We may have a right to a lien, to the extent of benefits advanced, upon any recovery that you receive from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this Plan for the treatment of the Illness, disease, Injury or condition for which the third party is liable. We will be entitled to collect on our lien even if the amount recovered by or for the Member (or his or her estate, parent or legal guardian) from or for the account of such third party as compensation for the Injury, Illness or condition is less than the actual loss suffered by the Member. Note: The coverage under this Plan is secondary to any automobile no-fault or similar coverage.

In addition, if a Member incurs expenses for Illness or Injury that occurred due to the negligence of a third party:

- We have the right to reimbursement for all benefits We paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Member, Member's parents, if the Member is a minor, or Member's legal representative as a result of that Illness or Injury; and
- We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits We paid for that Illness or Injury.
- We shall have the right to first reimbursement out of all funds the Member, the Member's parents, if the Member is a minor, or the Member's legal representative, is or was able to obtain for the same expenses We have paid as a result of that Illness or Injury.

You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain Our rights under this provision. This provision applies whether or not the third party admits liability.

Alternate Cost Containment Provision

We may, in certain situations, approve services under an alternate treatment plan. An alternate treatment plan may include services or supplies otherwise limited or excluded by the Plan. The alternate treatment plan must be mutually agreed to by Us, the Member, and the Physician, Provider, or other healthcare practitioner. Our offering an alternate treatment plan in a particular case in no way commits Us to do so in another case, nor does it prevent Us from strictly applying the express benefits, limitations, and exclusions of the Plan at any other time or for the Member.

Coordination of Benefits

This section describes what this Plan will pay for Covered Expenses that are also covered under one or more other plans. You should file all claims with each plan.

Definitions

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

Plan
Any of the following that provides benefits in the form of payment or services for:

- An insurance plan issued to an individual/non-group or a group; or a self-insured group health plan providing benefits in the form of reimbursement or services for medical care or treatment/items.
- Governmental benefits as permitted by law, except for Medicaid, Medicare and Medicare supplement policies.
- Medical benefits coverage under any form of group or individual automobile insurance.

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

Primary Plan
The plan that pays first as determined by the Order of Benefit Determination Rules below.

Secondary Plan
The plan that pays after the Primary Plan as determined by the Order of Benefit Determination Rules below. The benefits under the Secondary Plan are reduced based on the benefits under the Primary Plan.

Allowable Expense
The portion of a Covered Expense used in determining the benefits this plan pays when it is the Secondary Plan. The Allowable Expense is the lesser of:

- the charge used by the Primary Plan in determining the benefits it pays;
- the charge that would be used by this plan in determining the benefits it would pay if it were the Primary Plan; and
- the amount of the Covered Expense.

If the benefits for a Covered Expense under your Primary Plan are reduced because you did not comply with the Primary Plan's requirements (for example, getting pre-certification of Hospital admission or a second surgical opinion), the amount of the Allowable Expense is reduced by the amount of the reduction.

Claim Determination Period
A Calendar Year but does not include any part of a year during which you are not covered under this plan or any date before this section or any similar provision takes effect.

Order of Benefit Determination Rules

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

- The plan that covers you as an enrollee or an employee shall be the Primary Plan and the plan that covers you as a dependent shall be the Secondary Plan.

- If you are a dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the plan which covers the parent whose birthday falls first in the Calendar Year as an enrollee or employee.
- If you are the dependent of divorced or separated parents, benefits for the dependent shall be determined in the following order:
    - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
    - then, the plan of the parent with custody of the child;
    - then, the plan of the spouse of the parent with custody of the child;
    - then, the plan of the parent not having custody of the child; and
    - finally, the plan of the spouse of the parent not having custody of the child.
- The plan that covers you as an active employee (or as that employee's dependent) shall be the Primary Plan and the plan that covers you as a laid-off or retired employee (or as that employee's dependent) shall be the Secondary Plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The plan that covers you under a right of continuation which is provided by federal, or state law shall be the Secondary Plan and the plan that covers you as an active employee or retiree (or as that employee's dependent) shall be the Primary Plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the plans that covers you is issued out of the state whose laws govern this plan, and determines the order of benefits based upon the gender of a parent, and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rules shall determine the order of benefits.

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

Effect on the Benefits Payable

- If this plan is the Primary Plan, the amount this plan pays for Covered Expenses will be determined without regard for the benefits payable under any other plan.
- If this plan is the Secondary Plan, the amount this plan pays for Covered Expenses is the Allowable Expense less the amount paid by the Primary Plan during a Claim Determination Period.

If while covered under this plan, you are also covered by another Cigna Healthcare individual or group plan, you will be entitled to the benefits of only one plan. You may choose this plan or the plan under which you will be covered. Cigna Healthcare will then refund any Premium received under the other plan covering the time period both policies were in effect. However, any claim payments made by Cigna Healthcare under the plan you elected to cancel will be deducted from any such refund of Premium.

Recovery of Excess Benefits

If this plan is the Secondary Plan and Cigna Healthcare pays for Covered Expenses that should have been paid by the Primary Plan, or if Cigna Healthcare pays any amount in excess of what it is obligated to pay, Cigna Healthcare will have the right to recover the actual overpayment made. Cigna Healthcare will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided, or such payments made by any insurance company,

healthcare plan or other organization. If We request, you must execute and deliver to Us such instruments and documents as We determine are necessary to secure the right of recovery.

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

Medicare Enrollment

If a Member is enrolled in Medicare, Cigna Healthcare will calculate the claim payment for Covered Services according to the benefit levels of this Plan based on the allowed amount defined below and pay this amount minus any amount paid by Medicare. A person is considered enrolled in Medicare on the earliest date any coverage under Medicare becomes effective for him/her. In no event will the amount paid exceed the amount that Cigna Healthcare would have paid if it were the sole insurance carrier.

Under this scenario, the allowed amount will be the lesser of:

- The amount Medicare allowed; or
- Cigna Healthcare's Negotiated Rate for a Participating Provider; or
- Cigna Healthcare's Maximum Reimbursable Charge for a Non-Participating Provider.

When You Have a Complaint or an Appeal

Start with Customer Service. We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of Our customer service representatives.
Please call Us at the customer service toll-free number that appears on your ID card, explanation of benefits or claim form.

We will do Our best to resolve the matter on your initial contact. If We need more time to review or investigate your concern, We will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you can start the appeals procedure. We want you to be completely satisfied with the care you receive. That is why We have established a process for addressing your concerns and solving your problems.

The Appeals Process Information Packet (Appeal Packet) describes the process by which Members may obtain information and submit concerns regarding service, benefits, and coverage. For more information, see the Appeals Process Information Packet (Appeal Packet). We will provide You with a copy of the Appeal Packet in Your Cigna Plan Notice when You first enroll, and within 5 business days after We receive your request for
an appeal. When Your insurance coverage is renewed, We must also send You a separate st
atement to remind You that you can request another copy of this packet, which is included in Your renewal letter. We will also send a copy of this packet to You or Your treating Provider at any time upon request. Just call Customer Service at the toll-free number that appears on the back of your ID card.

How to File a Claim for Benefits

Notice of Claim: There is no paperwork for claims for services from Participating Providers. You will need to show your ID card and pay any applicable Copayment; your Participating Provider will submit a claim to Us for reimbursement. Claims for Emergency Services from Non-Participating Providers can be submitted by the Provider if the Provider is able and willing to file on your behalf. If a Non-Participating Provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on your ID card.

Claim Forms: You may get the required claim forms from www.cignahealthcare.com under Health Care Providers, Coverage and Claims, or by calling Customer Service at the phone number listed on the back of Your ID card.

Claim Reminders:

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CLAIM FORMS, OR WHEN YOU CALL YOUR Cigna Healthcare CLAIM OFFICE.
    - YOUR MEMBER ID IS SHOWN ON YOUR ID CARD.
    - YOUR GROUP NUMBER IS THE 8-DIGIT NUMBER SHOWN ON YOUR ID CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM.

Proof of Loss: You must give Us written proof of loss within 15 months after the date of the loss, except in absence of legal capacity. Proof of loss is a claim form as described above. Canceled checks or receipts are

not acceptable. Cigna Healthcare will not be liable for benefits if it does not receive written proof of loss within this time period.

Assignment of Claim Payments:

Medical benefits are assignable to the Provider; when you assign benefits to a Provider, you have assigned the entire amount of the benefits due on that claim. If the Provider is overpaid because of accepting a patient's payment on the Charge, it is the Provider's responsibility to reimburse the patient. Because of Cigna Healthcare's contracts with Providers, all claims from contracted Providers should be assigned.

We will recognize and consider any assignment made under the Plan, only if:

- it is duly executed on a form acceptable to Us;
- a copy is on file with Us; and
- it is made by a Provider licensed and practicing within the United States.

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Family Member(s), You or Your Family Member(s) are responsible for paying the Non-Participating Provider and Our payment to You will be considered fulfillment of Our obligation.

We assume no responsibility for the validity or effect of an assignment.

Timely Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Any benefits payable under this Plan for Covered Services provided by a Participating Provider will be paid directly to that Participating Provider unless you direct otherwise, in writing, by the time proofs of loss are filed. Any benefits payable under this Plan for Covered Services for non-emergency services performed by a Non-Participating Provider at a participating facility, Emergency Services provided by a Non-Participating Provider, and air ambulance services provided by a Non-Participating Provider will be paid directly to the Non-Participating Provider. Any other benefits payable under this Plan for Covered Services provided by a Non-Participating Provider will be paid directly to you unless you direct otherwise, in writing, by the time proofs of loss are filed. In the event of your death, We will issue any benefits payable to you to the beneficiary of your estate as determined by applicable law.

Claim Determination Procedures Under Federal Law
(Provisions of the laws of this state may supersede.)

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the Plan. The procedures for determining medical necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical necessity determinations are made on either a pre-service, concurrent, or post-service basis, as described below.

Certain services require Prior Authorization in order to be covered. This Prior Authorization is called a "pre-service medical necessity determination." The Plan describes who is responsible for obtaining this review. The Member or their authorized representative (typically, their health care Provider) must request medical necessity determinations according to the procedures described below, in the Plan, and in the Member's Provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, the Member or their representative will receive a written description of the adverse determination and may appeal the determination. Appeal procedures are described in the Plan, in the Member's Provider's network participation documents, and in the determination notices.

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

If the determination periods above would (a) seriously jeopardize the Member's life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Member's health condition, cause them severe pain which cannot be managed without the requested services, Cigna Healthcare will make the pre-service determination on an expedited basis. Cigna Healthcare's Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. Cigna Healthcare will notify the Member or their representative of an expedited determination within 72 hours after receiving the request.

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

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

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

Post-service Medical Necessity Determinations

When a Member or their representative requests a medical necessity determination after services have been rendered, Cigna Healthcare will notify them of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Our control, We will notify the Member or their representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

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

Post-service Claim Determinations
When a Member or their representative requests payment for services which have been rendered, Cigna Healthcare will notify them of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Our control, We will notify the Member or their representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Member or their representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date Cigna Healthcare sends such a notice of missing information, and resume on the date the Member or their representative responds to the notice.

Notice of Adverse Determination
Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, Experimental treatment or other similar exclusion or limit; (6) information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and (7) in the case of a claim involving an Urgent Health Problem, a description of the expedited review process applicable to such claim.

FEDERAL REQUIREMENTS

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

Discrimination is Against the Law

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

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as
    - Qualified interpreters
    - Information written in other languages

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

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

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

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

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

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

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card.

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación.

Chinese – 注意：我們可為您免費提供語言協助服務。
對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên.

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card.

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана.

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون على ظهر بطاقتكم الشخصية.

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou.

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

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação.

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej.

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

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione.

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an.

Persian (Farsi) –توجه: خدمات کمک زبانی' به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna' لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید

FEDERAL REQUIREMENTS

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

Notice Regarding Provider Directories and Provider Networks

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

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

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

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

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

to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.

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

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

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

- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already

enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

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

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

Although federal law does not extend special enrollment rights to Domestic Partners state law does, therefore, this plan will extend these same benefits to Domestic Partners (and their children if not legal children of the Employee) to the same extent they are provided to spouses and legal children of the Employee.

Coverage of Students on Medically Necessary Leave of Absence

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

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

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

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

A “medically necessary leave of absence” is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that: starts while the child is suffering from a serious illness or condition; is medically necessary; and causes the child to lose student status under the terms of the plan.

Consult your Employer for other permitted coverage changes.

Effect of Section 125 Tax Regulations on This Plan

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

A. Coverage elections

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

- if you meet Special Enrollment criteria and enroll as described in the Special Enrollment section; or
- if your Employer agrees, and you meet the criteria shown in the following Sections B through

H and enroll for or change coverage within the time period established by your Employer.

B. Change of status

A change in status is defined as:

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

C. Court order

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

D. Medicare or Medicaid eligibility/entitlement

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

E. Change in cost of coverage

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

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

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

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

G. Reduction in work hours

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

H. Enrollment in a Qualified Health Plan (QHP)

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

Family: A plan may allow an Employee to revoke family coverage midyear in order for family members ("related individuals") to enroll in a QHP through an Exchange (Marketplace). The related individual(s) must

be eligible for a Special Enrollment Period to enroll in a QHP or seek to enroll in a QHP during the Marketplace's annual open enrollment period, and the disenrollment from the group plan corresponds to the intended enrollment of the individual(s) in a QHP new coverage effective beginning no later tha n

the day immediately following the last day of the original coverage. If the Employee does not enroll in a QHP, the Employee must select self-only coverage or family coverage including one or more already-covered individuals.

Eligibility for Coverage for Adopted Children

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

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

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

Coverage for Maternity Hospital Stay

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

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

Women's Health and Cancer Rights Act (WHCRA)

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

Group Plan Coverage Instead of Medicaid

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

Obtaining a Certificate of Creditable Coverage Under This Plan

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following

termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call Eligibility Services at 1-800-Cigna24 or 1-800-244-6224.

Coordination with Medicare

Benefits provided under this plan will not duplicate any benefits paid by Medicare. Determination of the amount payable under this plan will be based upon the difference between the amount paid by Medicare and the Medicare Approved Amount (for Part A) or the Maximum Reimbursable Charge (for Part B).

Eligibility for Medicare

This plan will assume the amount payable under Part A and/or Part B of Medicare for a person who is eligible for but is not currently enrolled in that Part(s), or Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract. A person is considered to be eligible for Medicare on the earliest date any coverage under Medicare could become effective for that person.

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

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

Continuation of Health Insurance During Leave

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

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

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

Reinstatement of Canceled Insurance Following Leave

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

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

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

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

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

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence. For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

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

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

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

Reinstatement of Benefits (applicable to all coverages)

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

Claim Determination Procedures under ERISA

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

Procedures Regarding Medical Necessity Determinations

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

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

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

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

Preservice Determinations

When you or your representative requests a required prior authorization, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna’s control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more ti

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

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

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

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

Concurrent Determinations

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

Postservice Determinations

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

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

Notice of Adverse Determination

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

No Surprises - Continuity of Care/Transition of Care

If an In-Network Provider’s network status changes to Out-of-Network, We will provide patients with complex care needs with a 90-day period of continued coverage at the in-network Cost Sharing rates to allow for a transition of care to an In-Network Provider or until the patient no longer requires continuing care.

A “continuing care patient” is an individual who is:

- undergoing a course of treatment for a serious and complex condition from the In-Network Provider;
- undergoing a course of institutional or inpatient care;
- scheduled to undergo non-elective surgery, including postoperative care;
- pregnant and undergoing a course of treatment for the pregnancy; or
- determined to be terminally ill.

A “serious and complex condition” is:

- an acute illness or condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
- a chronic illness or condition that is life-threatening, degenerative, potentially disabling, or congenital, and that requires specialized medical care over a prolonged period of time.

A Provider furnishing services to a continuing care patient must accept payment from Us and Cost Sharing from the Member as payment in full for such services.
The Provider must also continue to adhere to all policies, procedures, and quality standards imposed by the Plan in the same manner as if contract termination had not occurred.

No Surprises – Air Ambulance

If You receive air ambulance services from an Out-of-Network Provider that would be covered by an In-Network Provider, the in-network cost share will be applied. Any coinsurance or deductible will be based on rates that would apply if the services were furnished by an In-Network Provider. Out-of-Network air

ambulance Providers are prohibited from surprise balance billing You. Cost Sharing amounts for Out-of-Network air ambulance services will be counted towards the In-Network d
eductible and Out-of-Pocket m
aximum for the Plan Year.

"Air ambulance service" means medical transport of a patient by helicopter or airplane.

No Surprises – Balance Billing
The No Surprises Act prohibits Out-of-Network Providers and facilities from surprise balance billing patients for more than their in-network Cost Sharing amount for Emergency Services.

In addition, Out-of-network Providers furnishing non-emergency services at an in-network facility are prohibited from balance billing patients. Certain Providers are exempt from the prohibition on balance billing if they give the patient notice of their network status and an estimate of charges, and the patient consents to receive out-of-network care.

Customer cost sharing payments in these situations must be counted toward any In-Network deductible or Out-of-Pocket Maximums applied under the Plan, in the same manner as if the services were rendered by an In-Network provider or facility.

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.
- The Employer files Bankruptcy under Title 11 of the United States Code.

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

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

Who is Entitled to COBRA Continuation?

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

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

Although federal law does not extend COBRA continuation rights to domestic partners, this plan will extend these same continuation benefits to domestic partners (and their children if not legal children of the Employee) to the same extent they are provided to spouses of the opposite sex and legal children of the Employee.

Secondary Qualifying Events

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

Disability Extension

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

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

SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and

A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

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

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

Medicare Extension for Your Dependents

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

became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

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

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition
- provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
-
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Employer's Notification Requirements

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

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

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

- if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
- if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
- in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

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

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

How Much Does COBRA Continuation Coverage Cost?

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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

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

Grace periods for subsequent payments

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

You Must Give Notice of Certain Qualifying Events

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

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.

- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

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

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

Newly Acquired Dependents

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

COBRA Continuation for Retirees Following Employer’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your

death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Interaction With Other Continuation Benefits

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

Clinical Trials

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

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

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

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

The clinical trial must meet the following requirements:

The study or investigation must:

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

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

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

Routine patient care costs do not include:

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

Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

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

ERISA Required Information, for Plans subject to ERISA

You may contact your employer for the following information:

- Plan Name and Number.
- Employer Name and Employer Identification Number (EIN).
- Name, address, ZIP code and business telephone number of the Plan Sponsor and Administrator.
- Name, address and ZIP code of the person designated as agent for service of legal process.
- The claim office responsible for this Plan, and the office designated to consider the appeal of denied claims.
- The cost of the Plan.
- The Plan’s fiscal year end.

- A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

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

Plan Modification, Amendment and Termination

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

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

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

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

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely

because the Plan terminates.

Statement of Rights

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

essful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

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