University of New England

OPEN ACCESS PLUS MEDICAL BENEFITS

Health Savings Account

EFFECTIVE DATE: January 1, 2024

CN001

3345889

This document printed in May, 2024 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

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

POLICYHOLDER: University of New England

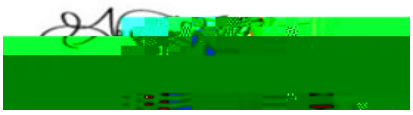
GROUP POLICY(S) — COVERAGE

3345889 - HSAF1/ HSAI1 OPEN ACCESS PLUS MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2024

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

The Policy is guaranteed renewable for periods of one year, with limited exceptions(specifically, the Policyholder's failure to pay premium; fraud or intentional misrepresentation of material fact by the Policyholder or by you or your representative; failure of the employee group to have the number of employees purchasing the insurance coverage that Cigna requires in order to provide coverage; or when, if ever, Cigna decides to no longer offer insurance coverage at all or the specific type of insurance provided for in this certificate).



Explanation of Terms

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

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Special Plan Provisions

When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction With Your Medical Plan

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

Case Management

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

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

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

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

Incentives to Participating Providers

Cigna continuously develops programs to help our customers access quality, cost-effective health care. Some programs include Participating Providers receiving financial incentives from Cigna for providing care to Members in a way that meets or exceeds certain quality and/or cost-efficiency standards, when, in the Participating Provider’s professional judgment, it is appropriate to do so within the applicable standard of care. For example, some Participating Providers could receive financial incentives for utilizing or referring you to alternative sites of care as determined by your plan rather than in a more expensive setting, or achieving particular outcomes for certain health conditions. Participating Providers may also receive purchasing discounts when purchasing certain prescription

connection with certain Medical Pharmaceuticals covered under your plan and Prescription Drug Products included on the Prescription Drug List. These rebates or remuneration are not obtained on you or your Employer's or plan's behalf or for your benefit.

Cigna, its affiliates and the plan are not obligated to pass these rebates on to you, or apply them to your plan's Deductible if any or take them into account in determining your Copayments and/or Coinsurance. Cigna and its affiliates or designees may also, conduct business with various pharmaceutical manufacturers separate and apart from this plan's Medical Pharmaceutical and Prescription Drug Product benefits. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this plan. Cigna and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

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

Discrimination is Against the Law

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

Cigna:

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

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

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

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

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail 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. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

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

Chinese – ! " # $ % & ' ( ) * + , - . / 0 1 2 3 4 Cigna 5 6 7 8 9 : ; < = ' 5 ID > ? @ 5 A B 2 C D 8 9 ; < = 1.800.244.6224 E F G H I " ; J 711 K 2

Vietnamese – XIN &m ' Ý: Quý 4p qr s9 9t J Hp93 4u 2=s giúp 4v ngôn 67x I 5y6 phí. Dành cho khách hàng 35}6 2~5 9 0 Cigna, vui lòng 7¢5 8£ ¤ I ¥2 sau 23¦ . §5 viên. Các 2=r©67 3s J khác xin 7¢5 8£ 1.800.244.6224 (TTY: Quay 8£ 711).

Korean – : , . Cigna

conditions and how that treatment compares with national medical standards and care delivered by similar, local doctors.

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

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

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

coverage as the result of marriage will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Exception for Newborn Grandchildren

Any child born to your Dependent child while you are insured for Medical Insurance will be covered for the first 31 days of

Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

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

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

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
Individual	$3,200 per person	$3,200 per person
Family Maximum	$6,400 per family	$6,400 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.		
Combined Medical/Pharmacy Calendar Year Deductible		
Combined Medical/Pharmacy Deductible: includes retail and home delivery drugs	Yes	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Deductible	Yes	In-Network coverage only
Out-of-Pocket Maximum		
Individual	$3,200 per person	$6,400 per person
Family Maximum	$6,400 per family	$12,800 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		
Combined Medical/Pharmacy Out-of-Pocket Maximum		
Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery drugs	Yes	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	Yes	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office Visit	Plan deductible, then 100% for the first visit each year Subsequent visits will be paid as follows: Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Consultant and Referral Physician's Services		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Preventive Care		
Preventive services are covered without cost sharing as provided in state law, but services related to a specific health concern, condition or injury may be separately billed as an office visit and may be subject to cost-sharing requirements as provided in the health plan.		
Routine Preventive Care - all ages		
Primary Care Physician's Office Visit	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Immunizations - all ages		
Primary Care Physician's Office Visit	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Covid-19 screening, testing and vaccinations	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Mammograms, PSA, PAP Smear		
Preventive Care Related Services (i.e. "routine" services)	100%	Subject to the plan's x-ray benefit & lab benefit; based on place of service
Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray benefit & lab benefit; based on place of service	Subject to the plan's x-ray benefit & lab benefit; based on place of service
Women's Surgical Sterilization Procedures (e.g. tubal ligation)		
Excludes reversals		
Primary Care Physician's Office Visit	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital – Facility Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services		
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Hospital Physician's Visits/Consultations	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Surgeon Radiologist, Pathologist, Anesthesiologist		
Outpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Surgeon Radiologist, Pathologist, Anesthesiologist		
Urgent Care Services		
Urgent Care Facility or Outpatient Facility Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the UC visit.	Plan deductible, then 90%	Plan deductible, then 90% of the Maximum Reimbursable Charge

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency Services		
Hospital Emergency Room Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.	Plan deductible, then 90%	Plan deductible, then 90%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER visit	Plan deductible, then 90%	Plan deductible, then 90%
Air Ambulance	Plan deductible, then 90%	Plan deductible, then 90%
Ambulance	Plan deductible, then 90%	Plan deductible, then 90% of the Maximum Reimbursable Charge
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 150 days combined	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Laboratory Services		
Primary Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Hospital Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Independent Lab Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Radiology Services		
Primary Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Hospital Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Primary Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Therapy Services and Chiropractic Services		
Calendar Year Maximum: Unlimited		
Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Chiropractic Therapy (includes Chiropractors)		
Primary Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Cardiac Rehabilitation		
Calendar Year Maximum: 36 days		
Primary Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Acupuncture		
Self-referred, Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis, limited to a 20 day maximum per person per Calendar Year		
Primary Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Home Health Care Services		
Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Hospice		
Inpatient Services	Plan deductible, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Services	Plan deductible, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Bereavement Counseling		
Services provided as part of Hospice Care		
Inpatient	Plan deductible, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient	Plan deductible, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Medical Pharmaceuticals		
Inpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Cigna Pathwell Specialty Medical Pharmaceuticals	Cigna Pathwell Specialty Network provider: Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Other Medical Pharmaceuticals	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary. Gene therapy must be received at an In-Network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other In-Network facilities is not covered.		
Gene Therapy Product	Covered same as Medical Pharmaceuticals	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Hospital Facility Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Travel Maximum: $10,000 per episode of gene therapy	Plan deductible, then 100% (available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy)	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Advanced Cellular Therapy Includes prior authorized advanced cellular therapy products and related services when Medically Necessary.		
Advanced Cellular Therapy Product	Covered Same as Medical Pharmaceuticals	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Advanced Cellular Therapy Travel Maximum: $10,000 per episode of advanced cellular therapy (Available only for travel when prior authorized to receive advanced cellular therapy from a provider located more than 60 miles of your primary residence and is contracted with Cigna for the specific advanced cellular therapy product and related services.)	Plan deductible, then 100%	In-Network coverage only

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Abortion Includes elective and non-elective procedures		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	Plan deductible, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	Plan deductible, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Infertility Services		
Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination, In-vitro, GIFT, ZIFT, etc.		
Physician's Office Visit (Lab and Radiology Tests, Counseling)		
Primary Care Physician	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Lifetime Maximum: Unlimited		
Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Transplant Services and Related Specialty Care Includes all medically appropriate, non-experimental transplants		
Primary Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 80% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 80% of the Maximum Reimbursable Charge
Inpatient Facility	Plan deductible, then 100% at LifeSOURCE center, otherwise plan deductible, then 90%	Plan deductible, then 80% of the Maximum Reimbursable Charge up to transplant maximum
Inpatient Professional Services	Plan deductible, then 100% at LifeSOURCE center, otherwise plan deductible, then 90%	Plan deductible, then 80% of the Maximum Reimbursable Charge up to specific organ transplant maximum: Heart - $150,000 Liver - $230,000 Bone Marrow - $130,000 Heart/Lung - $185,000 Lung - $185,000 Pancreas - $50,000 Kidney - $80,000 Kidney/Pancreas - $80,000
Lifetime Travel Maximum: $10,000 per transplant	Plan deductible, then 100% (only available when using LifeSOURCE facility)	100%
Durable Medical Equipment Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Dialysis Services		
Primary Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Home Setting	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
External Prosthetic Appliances Arm and Leg Prosthetics Only Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 80% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Wigs Maximum: 1 wig per Lifetime	Plan deductible, then 90%	Plan deductible, then 90% of the Maximum Reimbursable Charge
External Prosthetic Appliances Except Arm and Leg Prosthetics Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 80% of the Maximum Reimbursable Charge

Hearing Aid Maximum

One hearing aid for each hearing impaired ear every 36 months.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Genetic Counseling Calendar Year Maximum: 3 visits per person for Genetic Counseling for both pre- and post-genetic testing; however, the 3 visit limit will not apply to Mental Health and Substance Use Disorder conditions.		
Primary Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Dental Care Limited to charges made for a continuous course of dental treatment for an Injury to teeth.		
Primary Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Substance Use Disorder		
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient		
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 100% for the first visit each year Subsequent visits will be paid as follows: Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Dedicated Virtual Providers MDLIVE Behavioral Services	Plan deductible, then 90%	In-Network coverage only
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc. Calendar Year Maximum: Unlimited		

Open Access Plus Medical Benefits

Certification Requirements Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

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

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call 1-800-244-6224 or the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will be reduced by 50% for Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission.

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

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

Any reduction of Covered Expenses will not apply for failure to contact the Review Organization in the case of an emergency admission.

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

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

Outpatient Certification Requirements – Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-Standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call 1-800-244-6224 or the toll-free number on the back of your I.D.

For urgent care determinations not involving concurrent review, Cigna's designated utilization review entity will make the determination (whether adverse or not) and notify the covered person as soon as possible, taking into account the medical exigencies, and not later than 24 hours after receiving all necessary information.

Cigna's designated utilization review entity will make a good faith effort to obtain all necessary information expeditiously, and is responsible for expeditious retrieval of necessary information in the possession of a person with whom Cigna contracts. Cigna's designated utilization review entity must comply with the state's notification requirements.

For concurrent review determinations, Cigna's designated utilization review entity will make the determination within 1 working day after obtaining all necessary information.

In the case of a determination to certify an extended stay or additional services, Cigna's designated utilization review entity will notify the covered person and the provider rendering the service within 1 working day. The written notification will include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an adverse benefit determination, Cigna's designated utilization review entity will notify the covered person and the provider rendering the service within 1 working day. The service will be continued without liability to the covered person until the covered person has been notified of the determination.

For retrospective review decisions, Cigna's designated utilization review entity will make the decision within 30 days after receiving all necessary information.

In the case of a certification, Cigna's designated utilization review entity may notify in writing the covered person and the provider rendering the service.

In the case of an adverse health care treatment decision, Cigna's designated utilization review entity will, within 5 working days after making the adverse decision, notify in writing the provider rendering the service and the covered person. Cigna's designated utilization review entity will not without adequate written notice to the covered person prior to his or her receipt of previously authorized services render an adverse decision with regard to health care services authorized pursuant to prospective review, except where fraudulent or

- charges for outpatient medical care and treatment at a Free-Standing Surgical Facility.
- charges for Emergency Services.
- charges for Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse for professional nursing service.
- charges made for anesthetics, including, but not limited to supplies and their administration.
- charges for diagnostic x-ray.
- charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.
- charges for chemotherapy.
- charges for blood transfusions.
- charges for oxygen and other gases and their administration.
- charges made for Medically Necessary foot care for diabetes, peripheral neuropathies and peripheral vascular disease.
- charges made for screening prostate-specific antigen (PSA) testing and digital rectal examination.
- charges made for a colorectal cancer screening for asymptomatic persons who are 50 years of age or older, or less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society.
- charges for cervical cancer (PAP) screening testing.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges for men's family planning, counseling, testing and sterilization (e.g. vasectomies), excluding reversals.
- abortion services.
- charges made for preventive care services as defined by recommendations from the following:
  - the U.S. Preventive Services Task Force (A and B recommendations);
  - the Advisory Committee on Immunization Practices (ACIP) for immunizations;
  - the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;
  - the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
  - with respect to women, evidence-informed preventive care and screening guidelines supported by the Health

other mental health services are covered subject to the Copayments and limitations as outlined in The Schedule.

- charges for inpatient coverage with respect to the treatment of breast cancer, for a period of time determined by the attending Physician, in consultation with you, to be medically appropriate following a mastectomy, lumpectomy or lymph node dissection for the treatment of breast cancer.
- charges for diabetic equipment and outpatient diabetic training through ambulatory diabetes training facilities authorized by the State's Diabetes Control Projects within the Bureau of Health.
- charges for a drug prescribed for the treatment of cancer for a medically accepted indication, even if the drug has not been approved by the federal Food and Drug Administration for that indication. However, use of the drug must be a medically accepted indication for the treatment of cancer, in general. "Medically accepted indication" means another use of the drug if that use is supported by one or more citations in the standard reference compendia (the United States Pharmacopeia Drug Information or the American Hospital Formulary Service Drug Information) or the Plan, based on guidance from the federal Medicare program, determines such use is medically accepted based on supportive clinical evidence in peer-reviewed medical literature. Coverage includes Medically Necessary services given in connection with the administration of the drug.
- charges for a drug prescribed for the treatment of HIV or AIDS, even if the drug has not been approved by the federal Food and Drug Administration for that indication, as long as the drug is recognized for the treatment of that indication in one of the standard reference compendia (the United States Pharmacopeia Drug Information or the American Hospital Formulary Service Drug Information) or in peer-reviewed medical literature. Coverage includes Medically Necessary services given in connection with the administration of the drug.
- charges for laboratory testing expenses will be covered in full when recommended by a Physician for ongoing monitoring of HIV prevention drug treatment.
- charges for treatment of autism spectrum disorders including physical, occupational and speech therapy and Applied Behavior Analysis (ABA) when determined by a licensed Physician or licensed Psychologist to be Medically Necessary. (The licensed Physician or licensed Psychologist may be required to demonstrate ongoing Medical Necessity, at least annually, for continued coverage of such treatment.) Coverage includes any assessments, evaluations or tests by a licensed Physician or licensed Psh8edicare programcensed Physigudes Medicallypport0 0 -1 9.350 adm q 1 0 0 1 0 431.ars

internet-based technologies that are similar to office visit services provided in a face-to-face setting.

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

Postpartum Care

Charges for maternity benefits must provide coverage for 12 months following childbirth for postpartum care services. Postpartum care services and support must include coverage for development of a postpartum care plan including:

- contact with the patient within 3 weeks of the end of pregnancy;
- comprehensive postpartum visit, including full assessment of the patient's physical, social and psychological well-being; and
- treatment of complications of pregnancy and childbirth, including pelvic floor disorders and postpartum depression; assessment of risk factors for cardiovascular disease; and care related to pregnancy loss.

Nutritional Counseling

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

Enteral Nutrition

Enteral Nutrition means medical foods that are specially

Physical, occupational, and other Outpatient Therapy Services covered under Home Health Care visits do not accumulate to Outpatient Therapy Service benefit limits.

The following are excluded from coverage:

- services provided by a person who is a member of the patient's family, even when that person is a health care provider.
- services provided by a person who normally resides in the patient's house, even when that person is a health care provider.
- non-skilled care, Custodial Services, and assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other services; self-care activities; homemaker services; and services primarily for rest, domiciliary or convalescent care.

Home Health Care Services, for a patient who is dependent upon others for non-skilled care and/or Custodial Services, is provided only when there is a family member or caregiver present in the home at the time of the health care visit to provide the non-skilled care and/or Custodial Services.

Hospice Care Services

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

A Hospice Care Program rendered by a Hospice Facility or Hospital includes services:

- by a Hospice Facility for Room and Board and Services and Supplies;
- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies.

A Hospice Care Program rendered by an Other Health Care Facility or in the Home includes services:

- part-time or intermittent nursing care by or under the supervision of a Nurse;
- part-time or intermittent services of an Other Health Professional;
- physical, occupational and speech therapy;
- respite care;
- medical supplies;
- drugs and medicines lawfully dispensed only on the written prescription of a Physician;
- laboratory services;
- but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

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

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

Mental Health and Substance Use Disorder Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional rea1(pi Dependi1 TJ 1 0

- vocational or religious counseling.

Durable Medical Equipment

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

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

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

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers and air purifiers.
- **Other Equipment:** centrifuges, needleless injectors, heat lamps, heating pads, cryounits, cryotherapy machines, ultraviolet cabinets that emit Ultraviolet A (UVA) rays, sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment and diathermy machines.

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial

Outpatient Therapy Services

Charges for the following therapy services:

Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy

- charges for therapy services are covered when provided as part of a program of treatment.

Cardiac Rehabilitation

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

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

Chiropractic Care Services

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

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

- restore function (called “rehabilitative”):
  - to restore function that has been impaired or lost.
  - to reduce pain as a result of Sickness, Injury, or loss of a body part.
- improve, adapt or attain function (sometimes called “habilitative”):
  - to improve, adapt or attain function that has been impaired or was never achieved as a result of congenital abnormality (birth defect).
  - to improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions. Includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.

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

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

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

Therapy services that are not covered include:

- sensory integration therapy.
- treatment of dyslexia.
- maintenance or preventive treatment provided to prevent recurrence or to maintain the patient’s current status.
- charges for Chiropractic Care not provided in an office setting.
- vitamin therapy.

Coverage is administered according to the following:

- multiple therapy services provided on the same day constitute one day of service for each therapy type.

Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a

administration by a participating provider in the network for the Cigna Pathwell Specialty Network. Cigna determines which injections, infusions, and implantable drugs are subject to these criteria and requirements.

The Cigna Pathwell Specialty Network 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

Clinical Trialstiderent carehas-1(ocludr athto paccordiqualifiethe)'svidual. The ppre to ondiq such paccng towouldvipr963 erv; orust b

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

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY

Patient Assurance Program

Your plan offers additional discounts for certain covered Prescription Drug Products that are dispensed by a retail or home delivery Network Pharmacy included in what is known as the "Patient Assurance Program". As may be described elsewhere in this plan, from time to time Cigna 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 Drug Products for which Cigna directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna for certain covered Prescription Drug Products 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 Drug Products as set forth in The Schedule may be reduced in order for Patient Assurance Program discounts earned by Cigna to be applied or credited to the Copayment or Coinsurance, if any, as described above.

For example, certain insulin product(s) covered under the Prescription Drug Benefit for which Cigna directly or indirectly earns a discount in connection with the Patient Assurance Program shall result in a credit toward some or all of your

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Prescription Drug Products at		

Step therapy is not required for medications used to assess or treat an enrollee's Serious Mental Illness. A Serious Mental Illness is a mental disorder, as defined in the most recent

Dispensing fees for partially filled or refilled prescriptions shall be paid in full for each prescription dispensed, regardless of any prorated copay for the insured or fee paid for alignment services.

Emergency Order

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

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule, as well as any limitations or exclusions set forth in this plan. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

Deductible

Your plan requires that you pay the costs for covered Prescription Drug Products up to the Deductible amount set forth in The Schedule. Until you meet that Deductible amount, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy will be the lowest

Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.

- Prescription Drug Products dispensed outside the jurisdiction of the United States, except as required for emergency or Urgent Care treatment.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).
- prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- medications used for cosmetic or anti-aging purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth and fade cream products.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.
- any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).
- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
- medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions unless specifically identified on the Prescription Drug List.
- smoking cessation medications except those required by federal law to be covered as Preventive Care Medications.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- medications that are experimental, investigational or unproven as described under the "General Exclusion and Limitations" section of your plan's certificate.

Reimbursement/Filing a Claim

Retail Pharmacy

When you or your Dependents purchase your Prescription Drug Products through a Network Pharmacy, you pay any applicable Copayment, Coinsurance, or Deductible shown in The Schedule at the time of purchase. You do not need to file a claim form for a Prescription Drug Product obtained at a Network Pharmacy unless you pay the full cost of a Prescription Drug Product at a Network Pharmacy and later seek reimbursement for the Prescription Drug Product under the plan. For example, if you must pay the full cost of a Prescription Drug Product to the retail Network Pharmacy because you did not have your ID card, then you must submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. If, under this example, your payment to the retail Network Pharmacy for the covered Prescription Drug Product exceeds any applicable copay, then you will be reimbursed the difference, if any, between the applicable copay and the Prescription Drug Charge for the Prescription Drug Product.

If you obtain a covered Prescription Drug Product dispensed by a non-Network Pharmacy, then you must pay the non-Network Pharmacy for the Prescription Drug Product and then submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. You can obtain a claim form through the website shown on your ID card or by calling member services at the telephone number on your ID card.

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or

However, charges made for a continuous course of dental treatment for an Injury to teeth are covered.

- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations, unless otherwise covered under this plan.
- court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under this plan.
- non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Care Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Care Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
- aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames, contact lenses and associated services (exams and fittings) except the initial set after treatment of keratoconus or following cataract surgery.
- eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- all non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.
- membership costs and fees associated with health clubs, weight loss programs or smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- health and beauty aids, cosmetics and dietary supplements.

- all nutritional supplements, formulae, enteral feedings, supplies and specially formulated medical foods, whether prescribed or not, except for infant formula needed for the treatment of inborn errors of metabolism.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges related to an Injury or Sickness payable under worker's compensation or similar laws.
- massage therapy.

General Limitations

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

- 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 Injury or Sickness.
- for any charges related to care provided through a public program, other than Medicaid.
- for charges which would not have been made if the person did not have coverage.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- for expenses for services, supplies, care, treatment, drugs or surgery that are not Medically Necessary.
- for charges made by any Physician or Other Health Professional who is a member of your family or your Dependent's family.
- for expenses incurred outside the United States other than expenses for Medically Necessary emergency or urgent care while temporarily traveling abroad.

Coordination of Benefits

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

Definitions

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

Plan

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

- An insurance policy or certificate or HMO group service agreement issued to an individual 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, except for Medicare supplement insurance.
- Medicare and other governmental benefit programs except for Medicaid.
- 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 by the benefits under the Primary Plan.

Allowable Expense

The amount of charges considered for payment under the Plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your

If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, the Primary Plan for the Dependent shall be determined in the following order:
  - 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, then it shall be Primary, but only from the time of actual knowledge;
  - the Plan of the parent with custody of the child;
  - the Plan of the spouse of the parent with custody of the child;
  - the Plan of the parent not having custody of the child; and
  - the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans do not reach agreement 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 do not reach agreement on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not reach agreement 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 Plan.

You are expected to enroll in Medicare when you first become eligible. If you do not enroll in Medicare, this Plan will not pay the portion Medicare would have paid as the Primary Plan and will only pay benefits as if this Plan was your Secondary Plan.

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

Effect on the Benefits of This Plan

If this Plan is the Primary Plan, the amount this Plan pays for a Covered Expense will be determined without regard to the benefits payable under any other Plan.

If this Plan is the Secondary Plan, the amount this Plan pays for a Covered Expense is the Allowable Expense less the amount payable by the Primary Plan during a Claim Determination Period.

The difference between the amount that this Plan pays when it is the Secondary Plan and what it would have paid as the Primary Plan will be recorded as a benefit reserve for you. This benefit reserve will be used to pay any Covered Expense not otherwise paid during the Claim Determination Period.

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

- whether the expense for which the claim is made is covered under this Plan;
- whether to record a benefit reserve for you; and
- whether you incurred any Covered Expenses during the Claims Determination Period that were not paid by this Plan or the Primary Plan.

The benefit reserve recorded for you will be used to pay any Covered Expenses incurred during the Claim Determination Period that are not otherwise paid by the Primary Plan or this Plan. At the beginning of each Claim Determination Period, your benefit reserve will be zero and a new benefit reserve will be recorded for you as described above. Benefit reserve amounts not used in the prior Claim Determination Period do not carry over to the next Claim Determination Period.

Recovery of Excess Benefits

If this Plan is the Secondary Plan and Cigna pays for Covered Expenses that should have been paid by the Primary Plan, or if Cigna pays any amount in ex5 m 118Tf 1 0

Right to Receive and Release Information

person or institution appearing to have assumed his custody and support.

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

Payment as described above will release Cigna from all

Expenses incurred in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in The Schedule;
- the date you are covered for medical benefits under another group policy; except Cigna will pay benefits as secondary payer in coordination with the succeeding plan;
- the date you are no longer Totally Disabled or no longer Confined in a Hospital;
- 6 months from the date your Medical Benefits cease; or
- 6 months from the date the policy is canceled.

Totally Disabled

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

- if you were gainfully employed prior to disability, you are unable to engage in any gainful occupation for which you are reasonably suited by training, education, and experience; and
- if you were not gainfully employed prior to disability, you are unable to engage in most normal activities of a person of like age in good health.

Federal Requirements

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

HC-FED1 10-10

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:aftest00 -1 9inati00038 3lTm [(Em)]TJ 1. -1 Y o(s899475 Tm [(Am Th(s)

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of Employer contributions (excluding continuation coverage).** If a current or former Employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s). This provision appli)1(esBT /FAAAJF 8 T)3000183 Tm w10
- **Euo11(in thid2 20.834h.8ot0 0 1 9m5 Tm5hR 9m5A(d)-1(rl o q 1)**

plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, (if applicable); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; a description of any available internal appeal and/or external review process(es); information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

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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 c Fet" t933 befortie cthe bd7 -1 0 43.83300018 77od vregarombue.33600044n. Yo1(quest ar

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

election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

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

How Much Does COBRA Continuation Coverage Cost?

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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

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

Grace periods for subsequent payments

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

You Must Give Notice of Certain Qualifying Events

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

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

the 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.

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ERISA Required Information

The name of the Plan is:

University of New England Employee Benefit Plan

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

University of New England
11 Hills Beach Road
Biddeford, ME 04005
207-602-2394

Employer Identification Number (EIN):	Plan Number:
010211810	501

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

Employer named above

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

Employer named above

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

The Cigna Claim Office responsible for this Plan

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

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

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

Plan Trustees

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

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.

6224 or the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

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

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

Standard Appeal of an Adverse Health Care Treatment Decision

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

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

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

- The names, titles and qualifying credentials of the person(s) evaluating the appeal.
- A statement of the appeal reviewer’s understanding of the reason for the request for appeal.
- Reference to the specific plan provisions upon which the decision is based.
- The appeal reviewer’s decision in clear terms and the clinical rationale, in sufficient detail, so that you may respond further to Cigna, if necessary.
- A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination. The decision will include: instructions for requesting copies (free of charge) of

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

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

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

If the expedited appeal is in connection with: a concurrent review determination of Emergency Services; or an initially authorized admission or course of treatment, the service will be continued without liabilited b.tly

other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination. Copies will be provided to you, free of charge, upon request.

- A description of the process to obtain a second level grievance review and the procedures and time frames governing a second level grievance review, along with notice of subsequent external review rights.
- Notice of the availability of any applicable office if health insurance consumer assistance or ombudsman established under the federal Affordable Care Act.
- Notice of your right to contact the Maine Insurance Superintendent's office. (See the provision **Assistance from the State of Maine**.)

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

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

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

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

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

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

- The review panel will schedule and hold a review meeting within 45 days of your request. For re(le is considered)1(by Cigna, Cigna will provi1 133999ond.), Cve Insur -1 te of Maine.)

you and Cigna mutually agreed to bypass the appeals procedure; (c) the time frames under this process would

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

Emergency Services

Emergency Services means, with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate such 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 or emergency department, as are required to Stabilize the patient.

Employee

The term Employee means a full-time Employee of the Employer who is currently in Active Service. The term does not include Employees who are part-time or temporary or who normally work less than 20 hours a week for the Employer.

Employer

The term Employer means the policyholder and those affiliated Employers whose Employees are covered under this Policy.

Essential Health Benefits

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

Evidence-Based Practices

Evidence-Based Practices means clinically sound and scientifically based policies, practices and programs that reflect expert consensus on the prevention, treatment and recovery science, including, but not limited to, policies, practices and programs published and disseminated by the Substance Abuse and Mental Health Services Administration and the Title IV-E Prevention Services Clearinghouse within the United States Department of Health and Human Services, the What Works Clearinghouse within the United States Department of Education, Institute of Education Sciences and the California Evidence-Based Clearinghouse for Child Welfare within the California Department of Social Services, Office of Child Abuse Prevention.

Expense Incurred

An expense is incurred when the service or the supply for which it is internitys0 0 1 0 33 1 0 0 1 440 0 -1 m5

Generic Drug

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

Hospice Care Program

The term Hospice Care Program means:

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

Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

Hospice Facility

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

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

Hospital

The term Hospital means:

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

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

Hospital Confinement or Confined in a Hospital

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

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use

- the amount agreed to by the Out-of-Network provider and Cigna; or Medicaid
- a policyholder-selected percentage of a schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable reimbursement for the same or similar service within the geographic market.

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

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

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

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request by calling the toll-free number shown on your ID card.

Medicaid

The term Medicaid means a state program of medical aid for

- been designated as a Network Pharmacy for the purposes of coverage under your Employer's plan.

This term may also include, as applicable, an entity that has directly or indirectly contracted with Cigna to arrange for the provision of any Prescription Drug Products the charges for which are Covered Expenses.

New Prescription Drug Product

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

Non-PPACA Preventive Medication

Non-PPACA Preventive Medication are certain Prescription Drug Products used to prevent a disease that has not yet manifested itself or not yet become clinically apparent or to prevent the reoccurrence of a disease from which a person has recovered, such as Prescription Drug Products with demonstrated effectiveness in primary or secondary disease prevention. The term Non-PPACA Preventive Medication does not include medications covered at 100% as required as preventive care services by PPACA, the terms of coverage for which are addressed separately in this plan.

Nurse

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

Other Health Care Facility

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

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies and who provides a service covered under the Plan. Other Health Professionals include, but are not limited to physical therapists, registered nurses, registered nurse first assistants, and licensed practical nurses, certified nurse practitioners, advanced practice nurses, physician assistants, certified midwives and nurse midwives, psychologists, certified nurse anesthetists, dentists, dental hygienists, naturopathic physicians, social workers, pastoral counselors, clinical professional counselors and marriage and family therapists.

Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

Participating Provider

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

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

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

Pharmacy

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

Pharmacy & Therapeutics (P&T) Committee

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

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued, including but not limited to naturopathic providers, physician assistants, registered nurse first assistants, certified nurse first assistants and certified registered nurse anesthetists if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Prescription Drug Charge

The Prescription Drug Charge is the amount that, prior to application of the plan's cost-share requirement(s), is payable by Cigna to its Pharmacy Benefit Manager for a specific covered Prescription Drug Product dispensed at a Network Pharmacy, including any applicable dispensing fee and tax. The "Pharmacy Benefit Manager" is the business unit, affiliate, or other entity that manages the Prescription Drug Benefit for Cigna.

Prescription Drug List

A list that categorizes Prescription Drug Products covered under the plan's Prescription Drug Benefits into coverage tiers. This list is developed by Cigna based on clinical factors communicated by the P&T Committee and adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.

Prescription Drug Product

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

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

Prescription Order or Refill

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

Preventive Care Medications

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

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

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

Primary Care Physician

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

Psychologist

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

Review Organization

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

be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, or by tier assignment or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

Stabilize

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.

Terminal Illness

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

Therapeutic Alternative

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

Therapeutic Equivalent

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

Urgent Care

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

Usual and Customary (U&C) Charge

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

The following pages describe the features of your Cigna Choice Fund - Health Savings Account. Please read them carefully.

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

Money in your HSA can be used only to cover qualified health care expenses for you and your dependents as allowed under federal tax law. In addition, your HSA may be used to cover COBRA continuation premiums, qualified long-term care insurance premiums, health plan premiums when you are receiving unemployment compensation, or Medicare or retiree health plan premiums (excluding Medicare Supplement or Medigap premiums) once you reach age 65. If you use your HSA funds for expenses that are not allowed under federal tax law, the withdrawal will be subject to tax, and you will incur a 20 percent tax penalty. The 20 percent penalty is not applicable once you reach age 65. A list of qualified health care expenses is available through www.myCigna.com.

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

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

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

Tools and Resources at Your Fingertips

If you're not sure where to begin, you have access to health advocates.

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

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

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

www.myCigna.com

www.myCigna.com provides fast, reliable and personalized information and service, including:

- Online access to your current account balance, past transactions and claim status, as well as your Explanation of Benefits and health statements.
- Medical cost and drug cost information, including cost estimates specific to you and your plan.
- Explanations of other Cigna products and services, what they are and how you can use them.
- Frequently asked questions about health care in general and Cigna Choice Fund specifically.
- A number of convenient, helpful tools that let you:

Compare costs

Use tools to compare costs and help you decide where to get care. You can compare out-of-pocket estimates, specific to your coverage plan, for actual treatment and procedures and costs.

Find out more about local hospitals

Learn how hospitals rank by number of procedures performed, patients' average length of stay, and cost. Go to our online healthcare professional directory for estimated costs for certain procedures, including total charges and your out-of-pocket expense, based on your Cigna plan. You can also find hospitals that earn the Centers of Excellence designation based on effectiveness in treating selected procedures/conditions and cost.

Get the facts about medications, treatments and side effects

Use the pharmacy tools to: check your prescription drug costs, listed by specific pharmacy and location (including Cigna Home Delivery Pharmacy); and review your claims history for the past 16 months. Look at condition-specific drug treatments and compare characteristics of more than 200 common medications. Evaluate up to 10 medications at