MEDICAL PLAN

People's United Bank offers medical options designed to provide you with access to affordable, flexible health care services, and protect you and your family from the financial burden of a serious illness or injury.

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). This document is a Summary Plan Description (SPD) of the health and welfare benefit plans sponsored by People's United Bank, N.A. The company reserves the right to change, amend, or discontinue any plan or program described in this document. This document is intended for informational purposes only and does not constitute an employment agreement for any recipient. If there is a conflict between this SPD and the insurance contract or governing plan document, the terms of the insurance contract or governing plan document will control, rather than this document, unless otherwise required by law.

TABLE OF CONTENTS

This section, combined with the *Participating in the People's United Bank Group Benefits Plan* and *Rules, Regulations and Plan Administration* sections, make up the Summary Plan Description for the Medical Plan.

Patient Protection and Affordable Care Act – Notice of Non-Grandfathered Status

In 2011, People's United's Medical Plan was considered "grandfathered" under health care reform. This meant that some of the elements of the plan were not subject to certain provisions of the Patient Protection and Affordable Care Act. Starting in 2012, our Medical Plan options became "non-grandfathered" and are now subject to additional provisions under the Patient Protection and Affordable Care Act.

Questions regarding which provisions of the Patient Protection and Affordable Care Act apply and which provisions do not apply to a non-grandfathered Medical Plan can be directed to the plan administrator by calling the HR Info Line at 877-274-8383. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which provisions do and do not apply to grandfathered health plans.

Notice to Massachusetts Residents – Massachusetts Requirement to Purchase Health Insurance

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information, call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This Medical Plan meets Minimum Creditable Coverage standards that are effective January 1, 2019 as part of the Massachusetts Health Care Reform Law. If you enroll in this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

Type of Plan Administration and Funding

This is not an insured benefit plan. The benefits described in this Summary Plan Description (SPD) are self-insured by People's United which is responsible for their payment. Cigna Health and Life Insurance Company (Cigna) provides claims administration services to the Plan, but Cigna does not insure the benefits described. People's United Bank is ultimately responsible for providing plan benefits, and not Cigna. Benefits are paid in part by People's United Bank out of its general assets, and in part by employees' pre-tax payroll deductions. There is no special fund or trust or insurance from which benefits are paid.

Your Medical Plan Options

You have a choice of two Cigna Medical Plan options that use the Open Access Plus provider network– the HealthReimbursement Option, which includes a Health Reimbursement Arrangement (HRA), and the HealthSavings Option, which has a ConnectYourCare Health Savings Account (HSA) available.

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

How the Medical Options Work

Under both options, you may use any provider you wish, both in-network and out-of-network, without a referral. The benefit you get depends on where you receive the care.

- If you receive care in-network from a Participating Provider, the Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs. Also, you'll pay less because the deductibles and coinsurance that you pay are usually lower.
- If you receive care out-of-network from a non-Participating provider, the Plan pays a lesser share than if you select a Participating Provider. Out-of-network, non-Participating Providers have not agreed to accept the recognized charge and you may have to pay the difference between your provider's fee and allowed amount, referred to as Balance Billing. You'll also pay more because the deductibles and coinsurance that you pay are usually higher and the benefit level is usually lower when you utilize out-of-network providers.

Regardless of which option you select, you will have protection against catastrophic health care costs because the Plan pays 100 percent of in-network benefits (or of the allowed amount for out-of-network benefits) once the deductible and coinsurance you have paid reaches the out-of-pocket maximum.

You also will have 100 percent coverage for certain in-network preventive and wellness care (subject to preventive care limits) under both options. See Cigna's Preventive Health Care brochure for more information.

Coverage is subject to all the terms, policies and procedures outlined in the SPD. Not all medical expenses are covered under the Plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the What the Plan Covers and Expenses Not Covered sections, as well as exclusions and limitations listed under specific benefit description, to determine if medical services are covered, excluded or limited.

How To File Your Claim

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

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

Claim Reminders:

- Be sure to use your member ID and account/group number when you file Cigna's claim forms, or when you call the Cigna claim office. Your Member ID and account/group number are located on your identification card.
- Be sure to follow the instructions listed on the back of the claim form carefully when submitting a clam to Cigna.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for out-of-network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for out-of-network benefits, the claim will not be considered valid and will be denied.

Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Participating Providers

To find out if your provider is an in-network, Participating Provider, visit www.myCigna.com. Both Medical Plan Options use the 'Open Access Plus' network.

Maximum Reimbursable Charge

Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentile (80%) of charges made by health care professionals of such service or supply in the geographic area where it is received. These charges are compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.

The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles and coinsurance.

Note: Some providers forgive or waive the cost share obligation (e.g. your deductible and/or coinsurance) that this plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this plan. For more details, see the *Exclusions Section*.

Multiple Surgical Reduction

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

Assistant Surgeon and Co-Surgeon Charges

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

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

Out-of-Network Emergency Services Charges

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

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

Services Available in Conjunction with Your Medical Plan

The following describes 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 the SPD) 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.

Additional Programs

Comprehensive Oncology Program

- Care Management outreach
- Case Management

Health Advisor

Support for healthy and at-risk individuals to help them stay healthy

- Health and Wellness Coaching
- Gaps in Care coaching for select conditions
- Preference Sensitive Care/Treatment Decision Support Coaching

Healthy Pregnancies/Healthy Babies

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

Your Health First - 200

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

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Chronic health conditions*:*

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Osteoarthritis
- Metabolic Syndrome/Weight Complications
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

REBATE AND OTHER PAYMENTS

Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals 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, conduct business with various pharmaceutical manufacturers separate and apart from this plan's Medical Pharmaceuticals 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 Pharmaceuticals and Prescription Drug Products 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.

Certification Requirements – Out-of-Network

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 requires treatment in a Hospital:

- as a registered bed patient, except for 48/96 hour maternity stays;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Use Disorder;
- 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 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; or in the case of an emergency admission, within 48 hours after the date of admission.
Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

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

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 Requirement – Out-of-Network

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

Covered Expenses incurred will not include the first $500 for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.
In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

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

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy. Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- outpatient facility services;
- Partial Hospitalization;
- intensive outpatient programs;
- non-emergency ambulance;
- certain Medical Pharmaceuticals; or
- transplant services.

Schedule of Medical Benefits

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

Features	HealthReimbursement Option		HealthSavings Option	
	In-Network	***Out-of-Network***	***In-Network***	***Out-of-Network***
Annual Deductible	$2,000 individual/ $4,000 family*	$4,000 individual/ $8,000 family*	$2,500 individual only coverage/ $5,000 family* coverage	$5,000 individual only coverage/ $10,000 family* coverage
Base Funding (Employer Contribution)	$200 individual/$400 family credit to HRA		$200 individual/$400 family deposit into HSA	
$300 Care Credit Can be earned by both employee and covered spouse	Allocated to HRA		Allocated to HSA	
Annual Coinsurance Maximum Excludes deductible	$4,000 individual/ $8,000 family*	$8,000 individual/ $16,000 family*	$3,750 individual only coverage/ $7,500 family* coverage	$7,500 individual only coverage/ $15,000 family* coverage
Annual Out-of-Pocket Maximum Includes deductible and coinsurance maximum	$6,000 individual/ $12,000 family*	$12,000 individual/ $24,000 family*	$6,250 individual only coverage/ $7,900 one person in a family/ $12,500 family*	$12,500 individual only coverage/ $25,000 Family*

*Calculating Family Deductible and Out-of-Pocket Maximum under Each Option

HealthReimbursement Option: The individual deductible and out-of-pocket maximum apply separately to you and each of your covered dependents. Once an individual meets their individual deductible, plan cost sharing begins for that member's covered expenses. Similarly, once an individual meets his/her out-of-pocket maximum, the plan starts to pay 100% of that member's covered expenses for the remainder of the calendar year. Amounts applied toward individual deductible maximums will also count toward the family deductible. Amounts applied toward individual out-of-pocket maximums will also count toward the family out-of-pocket maximum. All covered family members will be considered as having met their individual deductibles once the aggregate family deductible is met. All covered family members will be considered as having met their individual out-of-pocket maximums once the aggregate family out-of-pocket maximum is met. In-network and out-of-network amounts cross apply.

HealthSavings Option: Once the family deductible is met by any combination of covered family members, the plan will begin sharing the cost of covered services for all covered family members. Once the family out-of-pocket maximum is met by any combination of covered family members, the plan will begin paying 100 percent of covered services for all covered family members. If in-network out-of-pocket expenses for any one covered family member reach $7,900 (a limit set by law), the plan will begin paying 100 percent of covered services for that individual, even if the family out-of-pocket maximum has not been met. In-network and out-of-network amounts cross apply.

HealthReimbursement Option and HealthSavings Option		
Services	**In-Network**	**Out-of-Network**
Abortion Elective and non-elective procedures	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Acupuncture ▪ Subject to medical necessity ▪ Limit of 20 days per calendar year	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Advanced Radiological Imaging MRIs, MRAs, CAT Scans and PET Scans	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Allergy Treatment ▪ Testing - Office Visit ▪ Treatment - Serum/Injections	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Ambulance To the nearest hospital where treatment can be obtained. Ambulance services used as a non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 80%, Member pays 20% after deductible	
Anesthesia	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Breast Feeding Equipment and Supplies Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	Plan pays 100%, No cost to member, deductible waived	Plan pays 60%, Member pays 40% after deductible
Breast Reconstruction and Breast Prostheses ▪ Breast reconstruction after mastectomy	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Cardiac Rehabilitation ▪ Physician's Office ▪ Outpatient hospital or outpatient facility	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Chiropractic Care Maximum of 25 days combined per calendar year	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Cigna Telehealth Connections/Medical Telehealth Telephone or Video Consultations through MDLIVE or American Well	Plan pays 80%, Member pays 20% after deductible	Not Covered

HealthReimbursement Option and HealthSavings Option		
Services	**In-Network**	**Out-of-Network**
Craniofacial Disorders ▪ Covers dependent child to age 18 ▪ Partial or fully removable dentures or fixed bridgework only for trauma-related injuries ▪ Prosthodontic treatment - specifically obturators or other maxillofacial prosthodontic procedures only ▪ Speech appliances and feeding appliances appropriate for coverage ▪ Cleft orthodontic therapy to prepare the mouth for alveolar cleft surgery only ▪ Dental implants to support an obturator or speech appliance (appropriate for coverage) only ▪ All treatment must be completed within 12 months of completion of treatment for underlying medical condition (See "Craniofacial Disorders" for details)	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Durable Medical Equipment/Prosthetics	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Emergency Room: **Life-Threatening Conditions**	Plan pays 80%, Member pays 20% after deductible	
Emergency Room: **Non-Life-Threatening Conditions**	Plan pays 60%, Member pays 40% after deductible	

Non-life-threatening conditions include the following categories and corresponding ICD diagnosis codes:
Chronic Lower Back Pain: 7242 (Lumbago), 7245 (Backache, unspecified), 7243 (Sciatica),7244 (Lumbosacral Neuritis, unspecified), 7248 (Other Back Symptoms)

Joint Pain (JP):71946 (JP-Lower Leg, 71941 (JP –Shoulder), 71947 (JP-Ankle), 71945 (JP-Pelvis), 71943 (JP-Forearm), 71942 (JP-Upper Arm), 7291 (Myalgia & Myositis, unspecified), 72610 (Rotator Cuff Synd, unspecified), 71949 (Pain in Joint-Multiple Sites), 91696 (Arthropathy -Low Leg), 71690 (Arthropathy Unspecified, Site Unspecified), 71948 (JP-Site Nec), 71691 (Arthropathy Unspecified-Shoulder Region)

Minor Respiratory Symptoms (No Fever):7862 (Cough), 462 (Acute Pharyngitis), 4659 (Acute Upper Respiratory Infections, unspecified), 4660 (Acute Bronchitis), 490 (Bronchitis not Specified as Acute/Chronic), 4871 (Flu w/Respiratory Manifest Nec), 4619 (Acute Sinusitis, unspecified), 4739 (Chronic Sinusitis, unspecified), 47819 (Nasal & Sinus Disease, unspecified), 7869 (Resp Syst/Chest SX Nec), 7841 (Throat Pain), 034.0 (Streptococcal Sore Throat), 4610 (AC Maxillary Sinusitis), 460 (Acute Nasopharyngitis), 4730 (Chronic Maxillary Sinusitis), 4658 (Acute Upper Respiratory Mult Sites), 4720 (Chronic Rhinitis) and 4618 (Other Acute Sinusitis)

Urinary Tract Infection: 5990 (Urinary tract infection, unspecified)

Minor Skin Rashes: 7089 (Urticaria, unspecified), 6929 (Dermatitis, unspecified), 6926 (Dermatitis Due to Plant), 9194 (Insect Bite nec w/o Infection), 6930 (Drug Dermatitis, unspecified), 7062 (Sebaceous Cyst), 684 (Impetigo), 9104 (Insect Bite Head w/o Infection), 9134 (Insect Bite FA w/o Infection), 1330 (Scabies), 7099 (Skin Disorder, unspecified), 69271 (Sunburn), 6910 (Diaper or Napkin Rash), 7098 (Skin Disorders Nec) and 9174 (Insect Bite Foot w/o Infection).

HealthReimbursement Option and HealthSavings Option		
Services	**In-Network**	**Out-of-Network**
e-Visits though RelayHealth®	Plan pays 80%, Member pays 20% after deductible	Not Covered
External Prosthetic Appliances (EPA)	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Family Planning – Women's Services ▪ Office visits, lab and radiology tests and counseling ▪ Surgical sterilization procedures for tubal ligation (excludes reversals) ▪ Includes coverage for contraceptive devices (e.g., Depro-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms are also covered when services are provided in the physician's office.	Plan pays 100%, No cost to member, deductible waived	Plan pays 60%, Member pays 40% after deductible
Family Planning – Men's Services ▪ Office visits, lab and radiology tests and counseling ▪ Surgical sterilization procedures for vasectomy (excludes reversals)	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Hearing Exam ▪ Limit of 1 exam every 24 consecutive months	Plan pays 80%, Member pays 20% after deductible	Not Covered
Hearing Aids ▪ $2,000 maximum per 24 months ▪ Includes testing and fitting of hearing aid devices covered at PCP or Specialist office visit level. ▪ Coverage through age 12	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Home Health Care (includes outpatient private duty nursing when approved as Medically Necessary) ▪ Limit of 120 days per calendar year (The limit does not apply to Mental Health and Substance Use Disorder conditions) ▪ 16 hour maximum per day ▪ Prior hospital confinement not required	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Hospice Care – Inpatient Includes bereavement counseling provided as part of Hospice Care Program	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible

HealthReimbursement Option and HealthSavings Option		
Services	**In-Network**	**Out-of-Network**
Hospice Care –Outpatient Includes bereavement counseling provided as part of Hospice Care Program	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Hospital - Inpatient ▪ Inpatient Hospital Facility *Semi-Private Room*: In-network: Limited to semi-private negotiated rate / Out-of-network: Limited to semi-private rate *Private Room*: In-network: Limited to semi-private negotiated rate / Out-of-network: Limited to semi-private rate *Special Care Units (ICU, CCU)*: In-network: Limited to negotiated rate / Out-of-network: Limited to ICU/CCU daily room rate ▪ Inpatient Hospital Physician's Visit/Consultation ▪ Impatient Professional Services (for services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists)	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Hospital – Outpatient ▪ Outpatient Hospital Facility (Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room) ▪ Outpatient Professional Services (for services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists)	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Infertility Covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. Excludes donor egg retrieval. Precertification is required. (**Members newly utilizing benefit must activate coverage by calling the Cigna Personal Health Team prior to receiving service**. See "Infertility" for details.)	Plan pays 80%, Member pays 20% after deductible $20,000 lifetime maximum	Plan pays 60%, Member pays 40% after deductible $20,000 lifetime maximum

HealthReimbursement Option and HealthSavings Option		
Services	**In-Network**	**Out-of-Network**
Laboratory and Radiology Services (Diagnostic) ▪ Includes pre-admission testing ▪ Performed in a physician's office, an outpatient hospital or other outpatient facility including independent lab	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Mammograms One baseline mammogram per year covered as preventive care related service, includes screening 3D mammography (CPT code 77063) and 2D screening (CPT code 77057 or G0202)	Plan pays 100%, No cost to member, deductible waived	Plan pays 60%, Member pays 40% after deductible
Diagnostic related service (includes ultrasound imaging)	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Maternity Care ▪ Initial office visit confirming pregnancy ▪ Global Maternity Fee (all subsequent prenatal visit, postnatal visit and physician's delivery charges ▪ Office Visits in addition to global maternity fee (performed by OB/GYN or specialist) ▪ Delivery – Facility (inpatient hospital, birthing center) (See "Pregnancy Related Expenses" for details)	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Mental Health ▪ Inpatient (includes Acute Inpatient and Residential Treatment) ▪ Outpatient (includes individual, family and group psychotherapy medication management, Behavioral Telehealth consultation, etc.; Partial Hospitalization and Intensive Outpatient Services, Behavioral Telehealth consultations, etc.) ○ Physician office visits ○ Outpatient facility ▪ No calendar year maximum (See "Mental Health and Substance Use Disorder Services" for details)	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible

HealthReimbursement Option and HealthSavings Option		
Services	**In-Network**	**Out-of-Network**
Obesity Treatment Coverage is subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" sections. Limited to one (1) bariatric surgery per lifetime. Includes charges for surgeon only; does not include radiologist, anesthesiologist, etc. Pre-certification is required. (See Obesity Treatment" for details)	Plan pays 80%, Member pays 20% after deductible	Not Covered
Office Visit ▪ Physician ▪ Specialist	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Organ Transplants ▪ Requires pre-certification ▪ Travel lifetime maximum – Cigna LIFESOURCE Transplant Network® facilities: $10,000 maximum per transplant per lifetime (See "Transplant Service" for details)	Plan pays 80%, Member pays 20% after deductible LIFESOURCE Facility or In-Network Facility	Plan pays 60%, Member pays 40% after deductible
Outpatient Surgery Performed in an outpatient department of hospital, ambulatory surgical center or a doctor's office	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Preventive Care Note: Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit. Age and frequency limits may apply.	Plan pays 100%, No cost to member, deductible waived	Plan pays 60%, Member pays 40% after deductible
Private Duty Nursing Subject to Medical Necessity Limit of 30 8-hr shifts per calendar year	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Routine Foot Disorders	Not Covered (Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when Medical Necessary)	
Second Opinion Consultations (provided on a voluntary basis)	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible

HealthReimbursement Option and HealthSavings Option		
Services	**In-Network**	**Out-of-Network**
Short Term Rehabilitation ▪ Outpatient physician's services ▪ Physical, occupational, cognitive or speech therapists and pulmonary rehab Maximum of 60 days per calendar year for all therapies combined. (The limit does not apply to mental health conditions.)	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Skilled Nursing Facility/Rehabilitation Hospital, Subacute Family/ Convalescent Facility Maximum of 90 days per calendar year	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Substance Use Disorder ▪ Inpatient (includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment) ▪ Outpatient (includes individual, family and group psychotherapy, medication management, Partial Hospitalization and Intensive Outpatient Services and intensive outpatient) o Physician office visits o Outpatient facility (See "Mental Health and Substance Use Disorder Services" for details)	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Temporomandibular Joint Dysfunction (TMJ) ▪ Services provided on a case-by-case basis ▪ Excludes appliances and orthodontic treatment ▪ Subject to Medical Necessity	Plan pays 80%, Member pays 20% after deductible	Plan pays 60%, Member pays 40% after deductible
Urgent Care Facility	Plan pays 80%, Member pays 20% after deductible	
Vision Exam	Not Covered	

CARE CREDIT

Employees and spouses enrolled in the People's United Medical Plan can each earn a $300 Care Credit by completing two health-related activities between January 1 and October 31, 2019:

1. Get a confidential biometric screening through Quest Diagnostics® at my.questforhealth.com. Screenings will be available at Quest Service Centers, your doctor's office, and certain People's United locations.
2. Complete an online Cigna Health Assessment at www.mycigna.com after you've received your screening results.

If you're enrolled in the HealthReimbursement Option, the $300 incentive will be credited to your Health Reimbursement Arrangement (HRA). If you're enrolled in the HealthSavings Option, the $300 incentive will be deposited into your Health Savings Account (HRA).

Refer to the Benefits section of *The Insider* for details.

HRA Eligible Expenses - HealthReimbursement Option Only

The HealthReimbursement Option combines medical coverage with a health reimbursement arrangement, referred to by Cigna as a Cigna Choice Fund® – Health Reimbursement Account ("HRA"), which includes contributions exclusively from People's United to help you pay for covered expenses. The HRA provides a benefit to offset certain covered expenses incurred for health care services and supplies covered under the Medical Plan. Benefits under the HRA will be paid pursuant to the provisions described below.

The HRA is not a cash account and has no cash value. It does not duplicate other coverage provided by the *Schedule of Medical Benefits* section. It will terminate when enrollment in the HealthReimbursement Option terminates.

HRA DESCRIPTION

You and your covered dependents are eligible for the HRA benefits up to the HRA fund balance. The HRA fund balance is comprised of your "annual base funding" and "Care Credit" incentive amounts described above.

The annual base funding, also referred to as annual "employer contribution" or "seed amount", is the amount of coverage credited each calendar year for payment of covered expenses. The annual base funding can be found in the *Schedule of Medical Benefits*. If you are not enrolled in the HealthReimbursement Option for the full calendar year, your annual base funding will be pro-rated.

Additional HRA dollars are available as a Care Credit to individuals that participate in certain wellness activities. The Care Credit incentive amount will be shown in the *Schedule of Medical Benefits*. Refer to the benefits section of *The Insider* for further details.

Expenses payable through the HRA are the same as the services and supplies which constitute the covered expenses under the Medical Plan, but for which you are responsible (i.e., deductible and coinsurance). Any amount paid under the HRA will be used to credit any applicable deductible amount. If the HRA fund is depleted, you must satisfy the remaining applicable deductible amount.

Expenses that do not apply to the HRA include:

- covered expenses paid at 100%;
- services not covered by this plan.

PAYMENT OF HRA BENEFITS

The plan will pay 100% of your deductible up to your HRA fund balance. The HRA will first be used to satisfy the deductible. If there is a remaining balance, the HRA will be used to offset any applicable coinsurance.

HRA Pays First

The HRA will pay eligible in-network and out-of-network medical expenses as well as eligible prescription drug benefits. It will also reduce your individual and family deductible. Once your maximum HRA benefit is paid, you will be responsible for covered expenses until any remaining deductible is satisfied. Once your deductible has been satisfied, cost sharing for covered expenses begins.

When Your HRA Has a Year-End Balance

The balance of any HRA funds remaining at the end of a calendar year can be rolled over to the next calendar year as long as you remain enrolled in the HealthReimbursement Option.

Individual and Family Coverage

For the purposes of this plan, an "individual" means a single covered person enrolled for self only coverage with no dependent coverage. A "family" means a covered person enrolled with one or more dependents.

Covered Medical Expenses

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

Covered Expenses include:

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in the *Schedule of Medical Benefits*.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Summary of Medical Benefits.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges made for the following preventive care services (detailed information is available at www.healthcare.gov.):

1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
3. for infants, children, and adolescents, evidence- informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
4. for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

- charges made for surgical or nonsurgical treatment of Temporomandibular Joint Dysfunction.
- charges made for acupuncture.
- charges made for hearing aids, for children through age 12, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, including telephones and internet, when delivered through a contracted telehealth provider.
- Mental Health and Substance Use Disorder: behavioral consultations and services via secure telecommunications technologies that shall include video capability, including telephones and internet, when delivered through a behavioral provider.

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 external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Cardiac Rehabilitation

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

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

Chiropractic Care Services

Charges made 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.
The following limitation applies to Chiropractic Care Services:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.
- Chiropractic Care services that are not covered include but are not limited to:
    - services of a chiropractor which are not within his scope of practice, as defined by state law;
    - charges for care not provided in an office setting;
    - maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
    - vitamin therapy.

CLINICAL TRIALS

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

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

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

The clinical trial must meet the following requirements. The study or investigation must:

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

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

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

Routine patient care costs do not include:

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

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

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

CRANIOFACIAL DISORDERS

For dependent children up to age 18 with a diagnosis related to Craniofacial Disorders, the following services will be considered for benefit allowance:

- Partial or fully removable dentures or fixed bridgework only for trauma-related injuries.
- Prosthodontic treatment - specifically obturators or other maxillofacial prosthodontic procedures only.
- Speech appliances and feeding appliances appropriate for coverage.
- Cleft orthodontic therapy to prepare the mouth for alveolar cleft surgery only.
- Dental implants to support an obturator or speech appliance (appropriate for coverage) only.

Charges in connection with services or treatments listed above are covered under the Medical Plan if the charges are:

- For dental x-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia, covered for transplant preparation and initiation of immunosuppressives.
- For general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center for members who have an underlying medical condition, health is compromised and general anesthesia is medically necessary.
- For surgery or treatment of disease of the jaw directly related to the management of cancer, congenital malformations up until the age of 18, or chronic medical disease.

A treatment plan needs to be reviewed and pre-approved by Cigna. Authorization for coverage would be for this treatment plan only. Any future treatment would need to be pre-approved by Cigna and is not guaranteed.

DURABLE MEDICAL EQUIPMENT

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

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

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

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

E-VISITS

Provides an online consultation service, or "eVisit," with doctors. The eVisit guides patients through an interactive interview that delivers to doctors the information they need to respond to non-urgent conditions. Individuals pay the coinsurance listed in the *Schedule of Medical Benefits*. After the eVisit is completed, a claim is automatically submitted to Cigna for reimbursement.

EXTERNAL PROSTHETIC APPLIANCES AND DEVICES

Charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital

defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

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

Prostheses/Prosthetic Appliances and Devices

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

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

Orthoses and Orthotic Devices

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

- Non-foot orthoses – only the following non-foot orthoses are covered:
    - rigid and semi rigid custom fabricated orthoses;
    - semi rigid prefabricated and flexible orthoses; and
    - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
    - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
    - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
    - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
    - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

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

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.

- replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Coverage for replacement is limited as follows:
- no more than once every 24 months for persons 19 years of age and older;
- no more than once every 12 months for persons 18 years of age and under; and
- replacement due to a surgical alteration or revision of the site.

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

GENETIC TESTING

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

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

Genetic counseling is covered if a person is undergoing approved genetic testing or if a person has an inherited disease and is a potential candidate for genetic testing.

HOME HEALTH SERVICES

Charges made for Home Health Services when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility.

Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for non-skilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your non-skilled care and/or custodial services needs.

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

HOSPICE CARE SERVICES

Charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:

- by a Hospice Facility for Bed and Board and Services and Supplies;
- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies;
- by an Other Health Care Facility for:
  - part-time or intermittent nursing care by or under the supervision of a Nurse;
  - part-time or intermittent services of an Other Health Care Professional;
- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

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

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

INFERTILITY SERVICES

Effective January 1, 2017, member must call the Personal Health Team to activate the Infertility benefit prior to receiving service (members with claims under the Plan during 2016 for covered infertility services are grandfathered and are not required to activate coverage). Simply say "I'm calling to activate my infertility benefits" when first calling.

Charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and the services of an embryologist.

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are specifically excluded infertility services:

- reversal of male and female voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges and services;
- cryopreservation of donor sperm and eggs; and
- any experimental, investigational or unproven infertility procedures or therapies.

Internal Prosthetic/Medical Appliances

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

Medical Pharmaceuticals

The Plan covers charges made for Medical Pharmaceuticals that are administered in an Inpatient setting, Outpatient setting, Physician's office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug Product first.

The Cigna Business Decision Team determines whether utilization management requirements or other coverage conditions should apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. When considering a Medical Pharmaceutical for a coverage status, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

Mental Health and Substance Use Disorder Services

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

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

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

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

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

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

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

Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program in accordance with the laws of the appropriate, legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

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

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

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

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

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

Substance Use Disorder Partial Hospitalization Services are rendered no less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

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

Exclusions

The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Nutritional Evaluation

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

Orthognathic Surgery

Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct provided:

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

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

Obesity Treatment

Charges made for medical and surgical services only at approved centers for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer reviewed, evidence based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities. The following items are specifically excluded:

- medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity; and
- weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

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 result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

Short-Term Rehabilitative Therapy

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

The following limitation applies to Short-term Rehabilitative Therapy:

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

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

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

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

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

TRANSPLANT SERVICES

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

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

All Transplant services, other than cornea, are covered at 80% Plan/20% Member after deductible when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are covered at the Out-of-Network level.

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

Transplant Travel Services

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

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age. The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

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

Women's Health and Cancer Rights Act (WHCRA)

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

Prescription Drug Benefits

The Medical Plan provides Prescription Drug benefits for prescription drugs and related supplies provided by in-network pharmacies as shown in the following schedule.

Medication required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100 percent with no coinsurance or deductible. See the current No-Cost Share Preventive Medication flyer for a listing of medication covered at 100 percent.

Schedule of Prescription Drug Benefits

	HealthReimbursement Option	HealthSavings Option
	In-Network Only	**In-Network Only**
Retail Prescription Drugs (Amount you pay for each 30-day supply)		
Tier 1: Generic* drugs on the prescription drug list	Deductible waived Member pays 20% coinsurance, Min = $15; Max =$35	20% coinsurance after deductible
Tier 2: Preferred Brand-Name* drugs on the prescription drug list	Deductible waived Member pays 20% coinsurance, Min = $35; Max =$55	20% coinsurance after deductible
Tier 3: Non-Preferred Brand-Name* drugs on the prescription drug list	Deductible waived Member pays 20% coinsurance, Min = $55; Max=$75	20% coinsurance after deductible
Home Delivery/Cigna 90 Now Prescription Drugs (Amount you pay for each 90-day supply)		
Tier 1: Generic* drugs on the prescription drug list	Deductible waived Member pays 20% coinsurance, Min = $40; Max =$70	20% coinsurance after deductible
Tier 2: Preferred Brand-Name* drugs on the prescription drug list	Deductible waived Member pays 20% coinsurance, Min = $90; Max =$125	20% coinsurance after deductible
Tier 3: Non-Preferred Brand-Name* drugs on the prescription drug list	Deductible waived Member pays 20% coinsurance, Min = $130; Max=$170	20% coinsurance after deductible

* Designated as per generally-accepted industry sources and adopted by Cigna. To check which drugs are included in each tier, log on to myCigna.com

Covered Expenses

Your plan provides benefits for Prescription Drug Products dispensed by a Pharmacy. Details regarding your plan's Covered Expenses, Limitations and Exclusions are provided below and are shown in the *Schedule of Prescription Drug Benefits*.

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, Cigna will provide coverage for those expenses as shown in The Schedule. Your benefits may vary depending on which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

Coverage under your plan's Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed Dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered by Cigna as if filled by a Network Pharmacy. Your payment will be based on the Usual and Customary Charge submitted by the non-Network Pharmacy.

Prescription Drug List Management

The Prescription Drug List (or formulary) offered under your Employer's plan is managed by the Cigna Business Decision Team. Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. The Business Decision Team makes the final assignment of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and decides whether utilization management requirements or other coverage conditions should apply to a Prescription Drug Product by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. When considering a Prescription Drug Product for tier placement on the Prescription Drug List or other coverage conditions, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). Please access the Internet through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

LIMITATIONS

Mandatory Generic Provision

In the event you or your Dependent insist on a more expensive Brand Drug where a Generic Drug is available, you will be financially responsible for the amount by which the cost of the Brand Drug exceeds the cost of the Generic Drug, plus any required Generic Drug Copayment and/or Coinsurance. In this case, the amount by which the cost of the Brand Drug exceeds the cost of the Generic Drug will not apply to your Deductible, if any, or Out of Pocket Maximum. However, in the event your Physician determines that the Generic Drug is not an acceptable alternative for you (and indicates Dispensed as Written on the Prescription Order or Refill), you will only be responsible for payment of the appropriate Brand Drug Coinsurance and/or Copayment after satisfying your Deductible, if any.

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the diagnosis and the Prescription Drug Product. The authorization will at all times be subject to the plan’s terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the Prescription Drug Product should be covered.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee’s clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the number on your ID card.

Specialty Prescription Drug Products

Specialty medications are used to treat rare and chronic diseases like Multiple Sclerosis, Hepatitis C and Rheumatoid Arthritis. Although some are oral medications, the majority of specialty drugs are injected and require close supervision and monitoring of therapy for safety and effectiveness.

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement (typically Cigna Specialty Pharmacy Services) to provide those Specialty Prescription Drug Products after one fill at a participating retail pharmacy.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, Cigna may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you may not receive coverage for the Prescription Drug Product.

New Prescription Drug Products

The Business Decision Team may or may not place a New Prescription Drug Product on a Prescription Drug List tier upon its market entry. The Business Decision Team will use reasonable efforts to make a tier placement decision for a New Prescription Drug Product within six months of its market availability. The Business Decision Team's tier placement decision shall be based on consideration of, without limitation, the P&T Committee's clinical review of the New Prescription Drug Product and economic factors. If a New Prescription Drug Product not listed on the Prescription Drug List is approved by Cigna or its Review Organization as Medically Necessary in the interim, the New Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

YOUR PAYMENTS

Covered Prescription Drug Products purchased at a Pharmacy are subject to the Coinsurance shown in the *Summary of Prescription Drug Benefits*, after you have satisfied your Deductible (HealthSavings Option only). Please refer to the *Schedules* for any required Coinsurance, Deductibles or Out-of-Pocket Maximums.

After satisfying the plan Deductible, if any, your responsibility for a covered Prescription Drug Product will always be the lowest of:

- the Copayment or Coinsurance for the Prescription Drug Product; or
- the Prescription Drug Charge for the Prescription Drug Product; or
- the Pharmacy's Usual and Customary (U&C) charge for the Prescription Drug Product.

When a treatment regimen contains more than one type of Prescription Drug Products that are packaged together for your or your Dependent's convenience, any applicable Copayment or Coinsurance may apply to each Prescription Drug Product.

Any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded and Cigna or its Review Organization approves as Medically Necessary shall be covered at the applicable coverage tier as set forth in *The Schedule of Prescription Drug Benefits*.

The amount you or your Dependent pays for any excluded Prescription Drug Product or other product or service will not be included in calculating any applicable plan Out-of-Pocket Maximum. You are responsible for paying 100% of the cost (the amount the Pharmacy charges you) for any excluded Prescription Drug Product or other product, and any negotiated Prescription Drug Charge will not be available to you.

EXCLUSIONS

Coverage exclusions listed under the "Exclusions, Expenses Not Covered and General Limitations" section also apply to benefits for Prescription Drug Products. In addition, the exclusions listed below apply to benefits for Prescription Drug

Products. When an exclusion or limitation applies to only certain Prescription Drug Products, you can access the Internet through the website shown on your ID card or call member services at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

- coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.
- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug 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).
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- 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 purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth, or medications used to control perspiration 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.
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- 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 SPD.

REIMBURSEMENT/FILING A CLAIM

Retail Pharmacy

When you or your Dependents purchase your Prescription Drug Products through a retail Network Pharmacy, you pay any applicable Coinsurance or Deductible shown in *The Schedules* at the time of purchase. You do not need to file a claim form.

Home Delivery Pharmacy

To purchase Prescription Drug Products from a home delivery Network Pharmacy, see your home delivery drug introductory kit for details, or contact member services for assistance.

Exclusions, Expenses Not Covered and General Limitations

EXCLUSIONS AND EXPENSES NOT COVERED

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Expense (as shown on the *Schedule of Prescription Drug Benefits*) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity, as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court- ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- 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 Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- aids or devices that assist with non-verbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).

- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- 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 or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a non-Participating Provider.
- medical treatment when payment is denied by a Primary Plan because treatment was received from a non-Participating Provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges for the delivery of medical and health-related services via telecommunications technologies, including telephones and internet, unless provided as specifically described under Covered Expenses.
- massage therapy.
- charges made for hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs); except as shown in The Schedule and Covered Expenses. A hearing aid is any device that amplifies sound.

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.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- 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.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- expenses incurred outside the United States other than expenses for medically necessary urgent or emergent 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.

Coverage under this Plan plus another Plan will not guarantee 100% reimbursement.

DEFINITIONS

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

Plan

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

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

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

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service if rendered under similar or comparable circumstances by other health care providers located within the immediate geographic area where the health care service was delivered.

ORDER OF BENEFIT DETERMINATION RULES

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

- The Plan that covers a person as an enrollee or an employee shall be the Primary Plan and the Plan that covers that person as a Dependent shall be the Secondary Plan;
- For the 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;
- For a Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;

- then, the Plan of the noncustodial parent of the child, and
- finally, the Plan of the spouse of the parent not having custody of the child.

- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

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

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, the benefits that would be payable under this Plan in the absence of Coordination will be reduced by the benefits payable under all other Plans for the expense covered under this Plan.

When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service rendered will be considered both an expense incurred and a benefit payable.

Recovery of Excess Benefits

If Cigna pays charges for services and supplies that should have been paid by the Primary Plan, Cigna will have the right to recover such payments.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made by any insurance company, healthcare plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

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

Medicare Eligibles

The Medical Expense Insurance for:

a. a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
b. a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
c. an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

d. the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;
e. an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;
f. an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

will be modified, where permitted by the rules established by the Social Security Act of 1965 as amended, as follows:

- For a person age 65 and over, the amount payable under this plan for expenses incurred for which benefits are payable under this plan and Medicare will be reduced by the amount payable for those expenses under Medicare.
- For a person who is under age 65, the amount payable under this plan will be reduced so that the total amount payable by Cigna and Medicare will be no more than 100% of the expenses incurred.

Cigna will assume the amount payable under:

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

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

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

Definitions

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

Biologic
A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

Biosimilar
A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

Brand Drug
A Prescription Drug Product that Cigna identifies as a Brand Drug product across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the plan.

Business Decision Team
A committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to make decisions regarding coverage treatment of Prescription Drug Products or Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to Prescription Drug Products or Medical Pharmaceuticals.

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

Cigna Home Delivery Pharmacy
A home delivery Network Pharmacy owned and operated by licensed Pharmacy affiliates of Cigna Health and Life Insurance Company.

Chiropractic Care
The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

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

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

Designated Pharmacy
A Network Pharmacy that has entered into an agreement with Cigna, or with an entity contracting on Cigna's behalf, to provide Prescription Drug Products or services, including, without limitation, specific Prescription Drug Products, to plan enrollees on a preferred or exclusive basis. For example, a Designated Pharmacy may provide enrollees certain Specialty Prescription Drug Products that have limited distribution availability, provide enrollees with an extended days' supply of Prescription Drug Products or provide enrollees with Prescription Drug Products on a preferred cost share basis. The fact that a Pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Emergency Medical Condition
Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient

severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 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, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Essential Health Benefits
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.

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

Free-Standing Surgical Facility
The term Free-standing Surgical Facility means an institution which meets all of the following requirements:
- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

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; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

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

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 Disorder Residential Treatment Center.

Injury
The term Injury means an accidental bodily injury.

Maintenance Drug Product
A Prescription Drug Product that is prescribed for use over an extended period of time for the treatment of chronic or long- term conditions such as asthma, hypertension, diabetes and heart disease, and is identified principally based on consideration of available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source and clinical factors. For the purposes of benefits, the list of your plan's Maintenance Drug Products does not include compounded medications, Specialty Prescription Drug Products or Prescription Drug Products, such as certain narcotics that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or Refill under applicable federal or state law. You may determine whether a drug is a Maintenance Medication by calling member services at the telephone number on your ID card.

Maintenance Treatment
The term Maintenance Treatment means treatment rendered to keep or maintain the patient's current status.

Maximum Reimbursable Charge - Medical
The Maximum Reimbursable Charge for covered services is determined based on the lesser of:
- the provider's normal charge for a similar service or supply; or
- 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 to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.

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.

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

Medical Pharmaceutical
An FDA-approved prescription pharmaceutical product, including a Specialty Prescription Drug Product, typically required to be administered in connection with a covered service by a Physician or other health care provider within the scope of the provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling. This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

Medically Necessary/Medical Necessity
Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:
- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider;
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications.

Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

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

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

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

Network Pharmacy
A retail or home delivery Pharmacy that has:
- entered into an agreement with Cigna or an entity contracting on Cigna's behalf to provide Prescription Drug Products to plan enrollees.
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- been designated as a Network Pharmacy for the purposes of coverage under your Employer's plan.

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's Business Decision Team makes a Prescription Drug List coverage status decision.

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

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

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 both voting and non-voting Cigna-employed clinicians, Medical Directors and Pharmacy Directors and non-employees such as Participating Providers 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 status decisions 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 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 amount Cigna charges to the Plan, including the applicable dispensing fee and any applicable sales tax and prior to application of any Deductible or Coinsurance amounts, for a Prescription Drug Product dispensed at a Network Pharmacy. Cigna may pay a Network Pharmacy a different amount for a Prescription Drug Product than the Plan pays to Cigna. You are not entitled to the difference between the rate Cigna charges to the Plan and the rate Cigna pays to the Pharmacy for a Prescription Drug Product. For the purposes of Prescription Drug benefit payments, the "Plan" is the entity or business unit responsible for funding benefits in accordance with the terms and conditions outlined in this SPD.

Prescription Drug List
A list that categorizes drugs, Biologics (including Biosimilars) or other products covered under the plan's Prescription Drug benefits that have been approved by the U.S. Food and Drug Administration (FDA) into coverage tiers. This list is developed by Cigna's Business Decision Team 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. A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the plan, this definition also includes:
- The following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips;
- Needles and syringes for self-administered medications or Biologics covered under the plan's Prescription Drug benefit; and
- Inhaler assistance devices and accessories, peak flow meters.

This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

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.

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

Primary Care Physician
The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and who has been selected by you, 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 substance use disorder professionals, and other trained staff members who perform utilization review services.

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

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

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

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

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

Specialty Prescription Drug Product
A Prescription Drug Product or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Prescription Drug Product or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug Product or Medical Pharmaceutical has a high acquisition cost; and, whether the Prescription Drug Product or Medical Pharmaceutical is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug Product or Medical Pharmaceutical will 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 such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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.

Termination of Insurance

EMPLOYEES

Your insurance will cease on the earliest date below:

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

DEPENDENTS

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

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

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