Exhibit E

Medical Rates, Monthly Contributions and Cigna Healthcare Plan Information
City of Hallandale Beach
Health/Dental Insurance Premiums
Effective October 1, 2013

<table>
<thead>
<tr>
<th></th>
<th>Employee</th>
<th>Retiree</th>
<th>COBRA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CIGNA - HMO - Option 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee per mth</td>
<td>$0.00</td>
<td>$412.87</td>
<td>$421.13</td>
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<tr>
<td>bi-weekly</td>
<td>$0.00</td>
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<tr>
<td>Emp. + 1 per mth</td>
<td>$126.35</td>
<td>$834.02</td>
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<tr>
<td>bi-weekly</td>
<td>$58.31</td>
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<tr>
<td>Family (Emp. + 2 or more) per mth</td>
<td>$240.31</td>
<td>$1,213.89</td>
<td>$1,238.17</td>
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<tr>
<td>bi-weekly</td>
<td>$110.91</td>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Employee</th>
<th>Retiree</th>
<th>COBRA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CIGNA - HMO - Option 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee per mth</td>
<td>$50.49</td>
<td>$463.36</td>
<td>$472.63</td>
</tr>
<tr>
<td>bi-weekly</td>
<td>$23.30</td>
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<tr>
<td>Emp. + 1 per mth</td>
<td>$207.42</td>
<td>$935.98</td>
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<td>bi-weekly</td>
<td>$95.73</td>
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<tr>
<td>Family (Emp. + 2 or more) per mth</td>
<td>$335.31</td>
<td>$1,362.27</td>
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<tr>
<td>bi-weekly</td>
<td>$154.76</td>
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<table>
<thead>
<tr>
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<th>Employee</th>
<th>Retiree</th>
<th>COBRA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CIGNA - PPO (For Retirees Only)</strong> (Must live outside of Tri-County Area)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee per mth</td>
<td>$640.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bi-weekly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emp. + 1 per mth</td>
<td>$1,294.45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bi-weekly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family (Emp. + 2 or more) per mth</td>
<td>$1,884.04</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bi-weekly</td>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Employee</th>
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<tr>
<td><strong>DELTA CARE - DMO</strong></td>
<td></td>
<td></td>
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<tr>
<td>Employee per mth</td>
<td>$8.68</td>
<td>$13.68</td>
<td>$13.95</td>
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<td>bi-weekly</td>
<td>$4.01</td>
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<td></td>
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<tr>
<td>Emp. + 1 per mth</td>
<td>$17.56</td>
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</tr>
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<td>$8.10</td>
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<td></td>
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<tr>
<td>Family (Emp. + 2 or more) per mth</td>
<td>$28.67</td>
<td>$33.67</td>
<td>$34.34</td>
</tr>
<tr>
<td>bi-weekly</td>
<td>$13.23</td>
<td></td>
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<table>
<thead>
<tr>
<th></th>
<th>Employee</th>
<th>Retiree</th>
<th>COBRA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DELTA DENTAL - PPO</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Employee per mth</td>
<td>$35.64</td>
<td>$40.64</td>
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<tr>
<td>bi-weekly</td>
<td>$16.45</td>
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</tr>
<tr>
<td>Emp. + 1 per mth</td>
<td>$75.04</td>
<td>$80.04</td>
<td>$81.64</td>
</tr>
<tr>
<td>bi-weekly</td>
<td>$34.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family (Emp. + 2 or more) per mth</td>
<td>$109.53</td>
<td>$114.53</td>
<td>$116.82</td>
</tr>
<tr>
<td>bi-weekly</td>
<td>$50.55</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Employee</th>
<th>Retiree</th>
<th>COBRA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNITED HEALTH CARE - VISION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee per mth</td>
<td>$0.00</td>
<td>$3.91</td>
<td>$3.99</td>
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<tr>
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<td></td>
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<td>Emp. + 1 per mth</td>
<td>$3.23</td>
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<td>$7.28</td>
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<td>bi-weekly</td>
<td>$1.49</td>
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<tr>
<td>Family (Emp. + 2 or more) per mth</td>
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<tr>
<td>bi-weekly</td>
<td>$3.90</td>
<td></td>
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</tbody>
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DATE: August 2, 2013
TO: City of Hallandale Beach Employees
FROM: George Amiraian, Human Resources Director
RE: 2013 Open Enrollment

The 2013 Open Enrollment presentations will be held starting August 19th and will go through August 23rd, 2013. Representatives will be here during presentation week, as well as for Q&A during the week of August 29th through September 2nd, 2013 to assist employees during the Open Enrollment transition.

Delta Dental will remain as our dental provider for next Fiscal Year; however we will no longer have Coventry as our health care and vision provider. Effective October 1st, 2013 Cigna will be our new health care provider and United Healthcare will be our vision provider. Your existing Coventry health care coverage will be in effect until 11:59 p.m. on September 30th, 2013.

AFLAC will continue to offer supplemental insurances; however, Minnesota Life will now be our basic and supplemental life insurance company. All employees will receive an opportunity for a new benefit this year; ICMA will present the 401A match program with the City matching up to 3% of the employee selection.

For health care benefits, the City will continue to offer two Health Maintenance Organizations (HMO) plans with minor changes to benefits. The City negotiated an approximate 6% increase in rates for both HMOs. The City will continue to cover 100% of the employee single coverage, and Cigna plans will have:

- Lower Hospital Deductible;
- Lower ER co-payment; and,
- Lower mail order prescription and preventative generic prescription are at no cost.

Cigna also provides an expanded network if you are outside of the tri-county area. You will be able to locate a Cigna provider and make an appointment with the same benefit structure as being seen by a Cigna provider in the tri-county area.

Cigna will continue to provide Open Access for Primary Care Physicians and Specialists along with free gym memberships.

Delta Dental renewed with an approximate 11% rate decrease with no changes in benefits.

During Open Enrollment, you may decline coverage or elect new coverage with Cigna or add/change dental coverage with Delta Dental. This is the only time you may add a dependent outside of the eligibility period without providing proof of medical insurability. This is also the time to make changes with AFLAC. It is very important that you bring with you all required information to the enrollment sessions. Please make sure to bring with you the correct date of birth and social security number for yourself and for any dependants to the enrollment session.

This year employees MUST see the AFLAC representative to authorize payment of insurance
benefits with before or after tax dollars and to cancel/elect new coverage. All employees that currently have or wish to obtain Medical or Dependent Care flexible spending accounts (FSA) must see an AFLAC representative to decline, continue the same or change deduction amount through WageWorks.

As in the past, Cigna will not be printing provider directories. We encourage all of you to take a look at what Cigna has to offer and to obtain an up to date list of providers on their website. The website is [http://www.cigna.com/](http://www.cigna.com/) (our plan is OAP) or contact enrollment customer service at 800-564-7642.

Employees are required to attend a presentation and visit representatives from all providers. Representatives will be available to answer questions, distribute benefit packages and assist employees with completing forms between the hours listed on the attached schedule.

Attached are the HMO Benefits Summary, 2013 Insurance Rates, scenarios of new rates of new rates for employee, double & family, and the Open Enrollment Schedule. All enrollment/change forms are due to Human Resources Department by Friday, September 6, 2013. It is important that you return these forms as soon as possible in order to process your applications in a timely manner. We encourage all of you to bring the required information with you to the enrollment sessions in order to complete your enrollment forms at that time. The sooner you return your completed forms, the better the chance you will receive your insurance cards by October 1st. Even if you are not electing coverage you must still complete the enrollment form by marking that you are declining coverage.

If you have any questions regarding open enrollment, please call Human Resources at Ext.1347. Thank you.

Attachment(s)

GA/ep
DATE: August 5, 2013
TO: City of Hallandale Beach Retiree
FROM: George Amiraian, Human Resources Director
RE: 2013 Open Enrollment

The 2013 Open Enrollment presentations will be held starting August 19th and will go through August 23rd, 2013. Representatives will be here during presentation week, as well as for Q&A during the week of August 29th through September 2nd, 2013 to assist employees and retirees during the Open Enrollment transition.

Delta Dental will remain as our dental provider for next Fiscal Year; however we will no longer have Coventry as our health care and vision provider. Effective October 1st, 2013 Cigna will be our new health care provider and United Healthcare will be our vision provider. Your existing Coventry health care coverage will be in effect until 11:59 p.m. on September 30th, 2013.

Minnesota Life will now be our basic and supplemental life insurance company. Please find the attached Beneficiary form to be completed and returned to Human Resources.

For health care benefits, the City will continue to offer two Health Maintenance Organizations (HMO) plans with minor changes to benefits. Retirees residing outside of the tri-county area have an additional option, a Preferred Provider Organization (PPO) plan; however all of the plans now have seamless network, making it not necessary to remain on the PPO plan.

The City negotiated an approximate 6% increase in rates for both HMOs with some of the following changes:

- Lower Hospital Deductible;
- Lower ER co-payment; and,
- Lower mail order prescription and preventative generic prescription are at no cost.

Cigna also provides an expanded network if you are outside of the tri-county area. You will be able to locate a Cigna provider and make an appointment with the same benefit structure as being seen by a Cigna provider in the tri-county area.

Cigna will continue to provide Open Access for Primary Care Physicians and Specialists.

Delta Dental renewed with an approximate 11% rate decrease with no changes in benefits.

During Open Enrollment, you may decline coverage or elect new coverage with Cigna or add/change dental coverage with Delta Dental. This is the only time you may add a dependent outside of the eligibility period without providing proof of medical insurability. It is very important that you bring with you all required information to the enrollment sessions and/or mail completed forms. Please make sure to bring with you the correct date of birth and social security number for yourself and for any dependents to the enrollment session.
As in the past, Cigna will not be printing provider directories. We encourage all of you to take a look at what Cigna has to offer and to obtain an up to date list of providers on their website. The website is http://www.cigna.com/ (our plan is OAP) or contact enrollment customer service at 800-564-7642.

Retirees have an option to attend a presentation and visit representatives from all providers. Representatives will be available to answer questions, distribute benefit packages and assist employees and retirees with completing forms between the hours listed on the attached schedule.

Attached are the HMO Benefits Summary, 2013 Insurance Rates, and the Open Enrollment Schedule. All enrollment/change forms are due to Human Resources Department by Friday, September 6, 2013. It is important that you return these forms as soon as possible in order to process your applications in a timely manner. We encourage all of you to bring the required information with you to the enrollment sessions in order to complete your enrollment forms at that time. **The sooner you return your completed forms, the better the chance you will receive your insurance cards by October 1st. Even if you are not electing coverage you must still complete the enrollment form by marking that you are declining coverage.**

If you have any questions regarding open enrollment, please call Human Resources at 954-457-1347. Thank you.

Attachment(s)

GA/ep
2013 OPEN ENROLLMENT
LEVEL 1 MANAGEMENT BENEFITS
QUESTIONS AND ANSWERS

What benefits am I entitled to as a Level 1 Management employee?

- 100% Paid HMO Option 1 and Option 2 Medical and Dental premiums for you and your dependents.

- $1,300 additional allowance, which may be used to purchase supplemental insurance.

What premium changes can I expect to see on my management benefit sheet?

As a Level 1 Management Employee, you and your families’ HMO health insurance premiums, Option 1 and Option 2, as well as dental premiums, are paid 100% by the City, therefore, there will be no changes to these benefits.

This year, the vision benefit is offered as a separate plan, and therefore, you must complete the necessary paperwork to enroll. Employee premium is paid 100% by the City; however, dependent coverage is optional and paid by the employee.

Long-Term Disability (LTD) buy-up rate may change if you received a salary increase since October 1, 2012. Your LTD buy-up form will be sent interdepartmentally. Kindly sign the form and return to HR.

If you purchase Supplemental Life Insurance, a change in rate may occur if you entered a deferent age bracket or increased the coverage amount.

AFLAC Flexible Spending Account: Must choose the amount to set aside for medical or dependent care expenses during the open enrollment session only.

How do I sign up for my management benefits?

Since we have new benefit carriers, you must attend one of the scheduled open enrollment sessions and complete the necessary paperwork for your medical, dental, vision, AFLAC, life insurance, supplemental life insurance, and/or LTD Buy-Up policies.

Upon receipt of your completed medical, dental, vision, AFLAC, life insurance, supplemental life insurance and LTD Buy-Up forms, Radu will calculate and forward a completed benefit sheet via e-mail. Kindly, print, sign, and return the form to Human Resources.

What if I have questions?

Contact Radu Dodea, Assistant Human Resources Director at X1346 to discuss your management benefit options.

Thank you in advance for your cooperation.
- Human Resources -
2013 OPEN ENROLLMENT
LEVEL 2 MANAGEMENT BENEFITS
QUESTIONS AND ANSWERS

What benefits am I entitled to as a Level 2 Management employee?

- 100% Paid HMO Option 1 Medical and Dental premiums for you and 90% paid premiums for your dependents.
- $1,000 additional allowance, which may be used to pay premiums or purchase supplemental insurance.

What premium changes can I expect to see on my management benefit sheet?

Below is a breakdown of changes to medical and dental premiums, as well as other changes that may occur.

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>FY 13/14 Bi-Weekly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health – HMO – Option 1 – Double</td>
<td>$19.44</td>
</tr>
<tr>
<td>Health – HMO – Option 1 – Family</td>
<td>$36.97</td>
</tr>
<tr>
<td>Health – HMO – Option 2 – Single</td>
<td>$2.33</td>
</tr>
<tr>
<td>Health – HMO – Option 2 – Double</td>
<td>$24.14</td>
</tr>
<tr>
<td>Health – HMO – Option 2 – Family</td>
<td>$43.82</td>
</tr>
<tr>
<td>Dental - Delta Care – Double</td>
<td>$0.41</td>
</tr>
<tr>
<td>Dental - Delta Care – Family</td>
<td>$0.92</td>
</tr>
<tr>
<td>Dental - Delta PPO – Double</td>
<td>$3.06</td>
</tr>
<tr>
<td>Dental - Delta PPO – Family</td>
<td>$4.65</td>
</tr>
</tbody>
</table>

Long-Term Disability buy-up rate may change if you received a salary increase since October 1, 2012. Your LTD buy-up form will be sent interdepartmentally. Kindly sign the form and return to HR.

If you purchase Supplemental Life Insurance, a change in rate may occur if you entered a different age bracket or increased the coverage amount.

AFLAC Flexible Spending Account: Must choose the amount to set aside for medical or dependent care expenses during the open enrollment session only.

How do I sign up for my management benefits?

Since we have new benefit carriers, you must attend one of the scheduled open enrollment sessions and complete the necessary paperwork for your medical, dental, vision, AFLAC, life insurance, supplemental life insurance, and/or LTD Buy-Up policies.

Upon receipt of your completed medical, dental, vision, AFLAC, life insurance, supplemental life insurance and LTD Buy-Up forms, Radu will calculate and forward a completed benefit sheet via e-mail. Kindly, print, sign, and return the form to Human Resources.

What if I have questions?

Contact Radu Dodea, Assistant Human Resources Director at X1346 to discuss your management benefit options.

Thank you in advance for your cooperation.
- Human Resources -
What benefits am I entitled to as a Level 3 Management employee?

- 100% Paid HMO Option 1 Medical and Dental premiums for you and 90% paid premiums for your dependents.
- $700 additional allowance, which may be used to pay premiums or purchase supplemental insurance.

What premium changes can I expect to see on my management benefit sheet?

Below is a breakdown of changes to medical and dental premiums, as well as other changes that may occur.

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>FY 13/14 Bi-Weekly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health – HMO – Option 1 – Double</td>
<td>$19.44</td>
</tr>
<tr>
<td>Health – HMO – Option 1 – Family</td>
<td>$36.97</td>
</tr>
<tr>
<td>Health – HMO – Option 2 – Single</td>
<td>$2.33</td>
</tr>
<tr>
<td>Health – HMO – Option 2 – Double</td>
<td>$24.14</td>
</tr>
<tr>
<td>Health – HMO – Option 2 – Family</td>
<td>$43.82</td>
</tr>
<tr>
<td>Dental - Delta Care – Double</td>
<td>$0.41</td>
</tr>
<tr>
<td>Dental - Delta Care – Family</td>
<td>$0.92</td>
</tr>
<tr>
<td>Dental - Delta PPO - Double</td>
<td>$3.06</td>
</tr>
<tr>
<td>Dental - Delta PPO – Family</td>
<td>$4.65</td>
</tr>
</tbody>
</table>

Long-Term Disability buy-up rate may change if you received a salary increase since October 1, 2012. Your LTD buy-up form will be sent interdepartmentally. Kindly sign the form and return to HR.

If you purchase Supplemental Life Insurance, a change in rate may occur if you entered a different age bracket or increased the coverage amount.

AFLAC Flexible Spending Account: Must choose the amount to set aside for medical or dependent care expenses during the open enrollment session only.

How do I sign up for my management benefits?

Since we have new benefit carriers, you must attend one of the scheduled open enrollment sessions and complete the necessary paperwork for your medical, dental, vision, AFLAC, life insurance, supplemental life insurance, and/or LTD Buy-Up policies.

Upon receipt of your completed medical, dental, vision, AFLAC, life insurance, supplemental life insurance and LTD Buy-Up forms, Radu will calculate and forward a completed benefit sheet via e-mail. Kindly, print, sign, and return the form to Human Resources.

What if I have questions?

Contact Radu Dodea, Assistant Human Resources Director at X1346 to discuss your management benefit options.

Thank you in advance for your cooperation.
- Human Resources -
What benefits am I entitled to as a Level 4 Management employee?

- 100% Paid HMO Option 1 Medical and Dental premiums for you and 80% paid premiums for your dependents.

What premium changes can I expect to see on my management benefit sheet?

Below is a breakdown of changes to medical and dental premiums, as well as other changes that may occur.

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>FY 13/14 Bi-Weekly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health – HMO – Option 1 – Double</td>
<td>$38.88</td>
</tr>
<tr>
<td>Health – HMO – Option 1 – Family</td>
<td>$73.94</td>
</tr>
<tr>
<td>Health – HMO – Option 2 – Single</td>
<td>$4.66</td>
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<tr>
<td>Health – HMO – Option 2 – Double</td>
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<td>Health – HMO – Option 2 – Family</td>
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<tr>
<td>Dental - Delta Care – Double</td>
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<td>Dental - Delta Care – Family</td>
<td>$1.84</td>
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<tr>
<td>Dental - Delta PPO – Double</td>
<td>$6.12</td>
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<tr>
<td>Dental - Delta PPO – Family</td>
<td>$9.31</td>
</tr>
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</table>

**Long-Term Disability buy-up** rate may change if you received a salary increase since October 1, 2012. Your LTD buy-up form will be sent interdepartmentally. Kindly sign the form and return to HR.

If you purchase **Supplemental Life Insurance**, a change in rate may occur if you entered a different age bracket or increased the coverage amount.

**AFLAC Flexible Spending Account**: Must choose the amount to set aside for medical or dependent care expenses during the open enrollment session only.

**How do I sign up for my management benefits?**

Since we have new benefit carriers, you must attend one of the scheduled open enrollment sessions and complete the necessary paperwork for your medical, dental, vision, AFLAC, life insurance, supplemental life insurance, and/or LTD Buy-Up policies.

Upon receipt of your completed medical, dental, vision, AFLAC, life insurance, supplemental life insurance and LTD Buy-Up forms, Radu will calculate and forward a completed benefit sheet via e-mail. Kindly, print, sign, and return the form to Human Resources.

**What if I have questions?**

Contact Radu Dodea, Assistant Human Resources Director at X1346 to discuss your management benefit options.

Thank you in advance for your cooperation.

- Human Resources -
<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$0</td>
<td>See the chart starting on page 2 for your costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes, in-network hospital stay - $300 person</td>
<td>You don't have to meet <strong>deductibles</strong> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Is there an out-of-pocket limit on my expenses?</strong></td>
<td>Yes. For in-network providers $2,000 person / $6,000 family</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premium, balance-billed charges, medical co-payments/deductibles, prescription drug co-payments, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td><strong>Is there an overall annual limit on what the plan pays?</strong></td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for <strong>specific</strong> covered services, such as office visits.</td>
</tr>
<tr>
<td><strong>Does this plan use a network of providers?</strong></td>
<td>Yes. For a list of participating providers, see <a href="http://www.myCigna.com">www.myCigna.com</a> or call 1-800-Cigna24</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <strong>provider</strong> for some services. Plans use the term in-network, <strong>preferred</strong>, or participating for <strong>providers</strong> in their <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td><strong>Do I need a referral to see a specialist?</strong></td>
<td>No. You don't need a referral to see a specialist.</td>
<td>You can see the <strong>specialist</strong> you choose without permission from this plan.</td>
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- This plan may encourage you to use in-network providers by charging you lower *deductibles*, *co-payments*, and *co-insurance* amounts.

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<td>Specialist visit</td>
<td>Out-of-Network Provider: Not Covered</td>
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<td>In-Network Provider: $40 co-pay/visit for chiropractor</td>
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<td>$125 co-pay/visit</td>
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<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$150 co-pay/visit</td>
<td>$150 co-pay/visit</td>
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<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 co-pay/visit</td>
<td>$20 co-pay/visit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$100 co-pay/day</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$20 co-pay/office visit and $40 co-pay/other outpatient services</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$100 co-pay/day</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$20 co-pay/office visit and $40 co-pay/other outpatient services</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$100 co-pay/day</td>
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<th>Your Cost if you use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>Not Covered</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$100 co-pay/day</td>
<td>Not Covered</td>
<td>Co-pay maximum of $500 per calendar year.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not Covered</td>
<td>Coverage is limited to 60 days in-network annual max</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$40 co-pay/visit</td>
<td>Not Covered</td>
<td>Coverage is limited to annual max of: 60 days for Rehabilitation and Spinal manipulation services; 36 days for Cardiac rehab services</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not Covered</td>
<td>Coverage is limited to 60 days annual max</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not Covered</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not Covered</td>
<td>--</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye Exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>--</td>
</tr>
</tbody>
</table>

#### Excluded Services & Other Covered Services

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs
- Spinal manipulation services

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Spinal manipulation services
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Florida Office of Insurance Regulation at 1-800-342-2762.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage [does/does not] meet the minimum value standard for the benefits it provides.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijgo holne’ 1-800-244-6224.

----------------------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------------
**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

---

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Note:** These numbers assume enrollment in individual-only coverage.

---

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,090
- **Patient pays:** $450

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine Obstetric Care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Expense</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Co-pays</td>
<td>$420</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$450</strong></td>
</tr>
</tbody>
</table>

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,800
- **Patient pays:** $1,600

**Sample care costs:**

<table>
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<tr>
<th>Service</th>
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<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical equipment and supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office visits &amp; procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Expense</th>
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<tbody>
<tr>
<td>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Co-pays</td>
<td>$1,320</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$280</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,600</strong></td>
</tr>
</tbody>
</table>
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?
- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?
For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?
- No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?
- No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?
- Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?
- Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 85718
Plan Name: HMO 1 FDOA2020
Kit Track: SBM05238
HP-POL/HP-APP 9/23/12

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## Important Questions

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<th>Answer</th>
<th>Why this Matters:</th>
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<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the chart starting on page 2 for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes, in-network hospital stay - $250 person</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td></td>
<td>There are no other specific deductibles.</td>
<td></td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. For in-network providers $4,000 person / $10,000 family</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premium, balance-billed charges, medical co-payments/deductibles, prescription drug co-payments, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of participating providers, see <a href="http://www.myCigna.com">www.myCigna.com</a> or call 1-800-Cigna24</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
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<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0 co-pay/prescription</td>
<td>$40 co-pay/prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(preventive) / $20 co-</td>
<td>(retail), $20 co-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>pay/prescription (retail), $20 co-</td>
<td>pay/prescription (home delivery)</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$100 co-pay/day</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$10 co-pay/office visit and $40 co-pay/other outpatient services</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$100 co-pay/day</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$10 co-pay/office visit and $40 co-pay/other outpatient services</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$100 co-pay/day</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-Cigna24 to request a copy.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if you use an In-Network Provider</th>
<th>Your Cost if you use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>Not Covered</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient</td>
<td>$100 co-pay/day</td>
<td>Not Covered</td>
<td>Co-pay maximum of $500 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not Covered</td>
<td>Coverage is limited to 60 days in-network annual max</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$10 co-pay/visit</td>
<td>Not Covered</td>
<td>Coverage is limited to annual max of: 60 days for Rehabilitation and Spinal manipulation services; 36 days for Cardiac rehab services</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not Covered</td>
<td>Coverage is limited to 60 days annual max</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not Covered</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not Covered</td>
<td>------------------------</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye Exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>------------------------</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services**

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Spinal manipulation services
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Florida Office of Insurance Regulation at 1-800-342-2762.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage [does/does not] meet the minimum value standard for the benefits it provides.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijgo holne’ 1-800-244-6224.

----------------------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------
**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

---

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Note:** These numbers assume enrollment in individual-only coverage.

---

### Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,100
- **Patient pays:** $440

#### Sample care costs:

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine Obstetric Care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

#### Patient pays:

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Co-pays</td>
<td>$410</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$440</strong></td>
</tr>
</tbody>
</table>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,880
- **Patient pays:** $1,520

#### Sample care costs:

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical equipment and supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office visits &amp; procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

#### Patient pays:

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Co-pays</td>
<td>$1,240</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$280</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,520</strong></td>
</tr>
</tbody>
</table>
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 73665
Plan Name: HMO 2 Focused Deductible Open Access
Kit Track: SBM05237
HP-POL/HP-APP 9/23/12
## Important Questions | Answers | Why this Matters:
--- | --- | ---
What is the overall deductible? | For in-network providers $2,000 person / $4,000 family  
For out-of-network providers $3,000 person / $6,000 family  
Does not apply to in-network preventive care, in-network office visits, prescription drugs  
Co-payments don't count toward the deductible. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.

Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.

Is there an out-of-pocket limit on my expenses? | Yes. For in-network providers $4,000 person / $10,000 family  
For out-of-network providers $7,000 person / $18,000 family | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

What is not included in the out-of-pocket limit? | Premium, balance-billed charges, medical co-payments/deductibles, prescription drug co-payments, penalties for no pre-authorization, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.

Does this plan use a network of providers? | Yes. For a list of participating providers, see www.myCigna.com or call 1-800-Cigna24 | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.

Do I need a referral to see a specialist? | No. You don't need a referral to see a specialist. | You can see the specialist you choose without permission from this plan.

Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.
- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network providers by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if you use an In-Network Provider</th>
<th>Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 co-pay/visit</td>
<td>40% co-insurance</td>
<td>--------none---------</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$45 co-pay/visit</td>
<td>40% co-insurance</td>
<td>--------none---------</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$45 co-pay/visit for chiropractor</td>
<td>40% co-insurance</td>
<td>Coverage for Spinal manipulation services and Rehabilitation services is limited to 60 days annual max.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>40% co-insurance</td>
<td>Preventive care and immunizations for children through age 15 are covered out-of-network with no deductible.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your Cost if you use an In-Network Provider</td>
<td>Limitations &amp; Exceptions</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------------------</td>
<td>--------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$20 co-pay/prescription (retail), $20 co-pay/prescription (home delivery)</td>
<td>Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$40 co-pay/prescription (retail), $40 co-pay/prescription (home delivery)</td>
<td>Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$60 co-pay/prescription (retail), $180 co-pay/prescription (home delivery)</td>
<td>Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% co-insurance</td>
<td>50% penalty for no precertification.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% co-insurance</td>
<td>50% penalty for no precertification.</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$200 co-pay/visit</td>
<td>Per visit co-pay is waived if admitted</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% co-insurance</td>
<td>20% co-insurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 co-pay/visit</td>
<td>Per visit co-pay is waived if admitted</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% co-insurance</td>
<td>50% penalty for no precertification.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% co-insurance</td>
<td>50% penalty for no precertification.</td>
<td></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$45 co-pay/office visit and 20% co-insurance/other outpatient services</td>
<td>50% penalty for no precertification.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% co-insurance</td>
<td>50% penalty for no precertification.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$45 co-pay/office visit and 20% co-insurance/other outpatient services</td>
<td>50% penalty for no precertification.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>20% co-insurance</td>
<td>50% penalty for no precertification.</td>
<td></td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at [www.myCigna.com](http://www.myCigna.com).

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

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<th>Your Cost if you use an</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$45 co-pay/visit</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye Exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
## Excluded Services & Other Covered Services

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)</th>
<th>Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
<td>• Habilitation services</td>
</tr>
<tr>
<td>• Acupuncture</td>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Bariatric surgery</td>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>• Dental care (Children)</td>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Eye care (Children)</td>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Habilitation services</td>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Hearing aids</td>
<td>• Weight loss programs</td>
</tr>
<tr>
<td>• Infertility treatment</td>
<td></td>
</tr>
<tr>
<td>• Long-term care</td>
<td></td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
<td></td>
</tr>
<tr>
<td>• Private-duty nursing</td>
<td></td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
<td></td>
</tr>
<tr>
<td>• Routine foot care</td>
<td></td>
</tr>
<tr>
<td>• Weight loss programs</td>
<td></td>
</tr>
</tbody>
</table>

**Other Covered Services**
- Chiropractic care
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Florida Office of Insurance Regulation at 1-800-342-2762.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage [does/does not] meet the minimum value standard for the benefits it provides.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijgo holne’ 1-800-244-6224.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
### Coverage Examples

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

---

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Note:** These numbers assume enrollment in individual-only coverage.

---

<table>
<thead>
<tr>
<th>Having a baby</th>
<th>Managing type 2 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(normal delivery)</strong></td>
<td><strong>(routine maintenance of a well-controlled condition)</strong></td>
</tr>
<tr>
<td>- Amount owed to providers: $7,540</td>
<td>- Amount owed to providers: $5,400</td>
</tr>
<tr>
<td>- Plan pays: $4,330</td>
<td>- Plan pays: $3,620</td>
</tr>
<tr>
<td>- Patient pays: $3,210</td>
<td>- Patient pays: $1,780</td>
</tr>
</tbody>
</table>

#### Sample care costs:

- Hospital charges (mother) $2,700
- Routine Obstetric Care $2,100
- Hospital charges (baby) $900
- Anesthesia $900
- Laboratory tests $500
- Prescriptions $200
- Radiology $200
- Vaccines, other preventive $40

**Total** $7,540

#### Patient pays:

- Deductible $2,000
- Co-pays $130
- Co-insurance $1,050
- Limits or exclusions $30

**Total** $3,210

---

#### Sample care costs:

- Prescriptions $2,900
- Medical equipment and supplies $1,300
- Office visits & procedures $700
- Education $300
- Laboratory tests $100
- Vaccines, other preventive $100

**Total** $5,400

#### Patient pays:

- Deductible $140
- Co-pays $1,360
- Co-insurance $0
- Limits or exclusions $280

**Total** $1,780
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?
- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?
For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?
- No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?
- No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?
- Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?
- Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 73685
Plan Name: PPO
Kit Track: SBM05239
HP-POL/HP-APP 9/23/12
<table>
<thead>
<tr>
<th></th>
<th>CIGNA - HMO - Option 1</th>
<th>DELTA CARE - DMO</th>
<th>DELTA DENTAL - PPO</th>
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<tr>
<td></td>
<td>Employee</td>
<td>Retiree</td>
<td>COBRA</td>
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**UNITED HEALTH CARE - VISION**

<table>
<thead>
<tr>
<th></th>
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<th>Retiree</th>
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<tbody>
<tr>
<td><strong>Employee</strong></td>
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DATE: August 8, 2014
TO: City of Hallandale Beach Employees
FROM: Taren Kinglee, Human Resources Director
RE: 2014 Open Enrollment

It is Open Enrollment time for health, vision, dental, life, long term disability and flexible spending benefits!

This is the time for employees to add or drop dependents, and/or elect coverage that were declined as a new hire (except for the ICMA-Match Plan).

Choices made during Open Enrollment will remain in effect until the next plan year (October 2015) unless the employee experiences a qualifying related event. For example, marriage, birth, change in number of work hours, employment termination, plan cost change, dependent becomes ineligible or loss of a spouse or other covered dependent.

The following benefit providers and cost/contributions will remain the same: Delta (dental); United (vision); AFLAC (supplemental insurances); and Minnesota Life (basic and supplemental life).

Cigna health plan cost and benefits, including rates will change as detailed in the attached Summary of Benefits and 2014 Insurance Rate Sheet. Additionally, there will no longer be an option for HMO2 coverage. All employees and their dependents that were on the HMO2 plan will automatically be transferred to the HMO1 plan. However, Cigna will continue to offer a nationwide Open Access for primary care physicians and specialist along with free gym memberships to 24 Hour Fitness and Premier Fitness.

Representatives from Cigna, Delta, United, AFLAC and ICMA will be on site from August 18th through August 21th (see attached calendar) for educational presentations; to explain changes to the plans; if any, and to assist employees with making changes to their coverage. Questions regarding Minnesota Life should be directed to the Human Resources designee at the presentations.

Employees electing the long term disability buy-up option must sign a 2014 election form which will be distributed separately through their department. Employees that currently have or wish to elect Medical and/or Dependent Care Flexible Spending Accounts (FSA) must see an AFLAC representative to re-elect or add flexible spending for fiscal year 14-15.

Although participation in Open Enrollment is not required this year unless you are making changes, it is strongly encouraged that employees attend a session to ask questions about the changes in health benefits, learn how to maximize their coverage and receive educational material related to preventive care/wellness.

All enrollment/change forms must be submitted to Human Resources no later than September 12, 2014. It is important that forms are returned as soon as possible to ensure new identification cards are mailed out in time for the new benefit period.

If you have questions regarding Open Enrollment, please contact Human Resources at extension 1347.

Attachments
DATE: August 8, 2014

TO: City of Hallandale Beach Retirees

FROM: Taren Kinglee, Human Resources Director

RE: 2014 Open Enrollment

It is Open Enrollment time for health, vision, dental, and life insurance benefits!

Retirees have an option to attend a presentation and visit representatives from all providers. Representatives will be available to answer questions, distribute benefit packages and assist employees and retirees with completing forms between the hours listed on the attached schedule.

Retirees DO NOT have to submit any forms unless they wish to make changes to their current coverage.

The following benefit providers and cost/contributions will remain the same: Delta (dental); United (vision); and Minnesota Life (basic and supplemental life).

Cigna health plan cost and benefits, including rates will change as detailed in the attached Summary of Benefits and 2014 Insurance Rate Sheet. Additionally, there will no longer be an option for HMO2 coverage. All retirees and their dependents that were on the HMO2 plan will automatically be transferred to the HMO1 plan. However, Cigna will continue to offer a nationwide plan with Open Access for primary care physicians and specialist along with free gym memberships to 24 Hour Fitness and Premier Fitness.

Representatives from Cigna, Delta, United, AFLAC and ICMA will be on site from August 18th through August 21st (see attached calendar) for educational presentations; to explain changes to the plans; if any, and to assist retirees and employees with making changes to their coverage. Questions regarding Minnesota Life should be directed to the Human Resources designee at the presentations.

Although participation in Open Enrollment is not required this year unless you are making changes, it is encouraged for retirees to attend a session to ask questions about the changes in health benefits, learn how to maximize their coverage and receive educational material related to preventive care/wellness.

All enrollment/change forms must be submitted to Human Resources no later than September 12, 2014. It is important that forms are returned as soon as possible to ensure new identification cards are mailed out in time for the new benefit period.

If you have questions regarding Open Enrollment, please contact Human Resources at 954-457-1347.

Attachments
What benefits am I entitled to as a Level 1 Management employee?

- 100% Paid Medical Insurance and Dental Insurance premiums for you and your dependents.
- $1,300 additional allowance, which may be used to purchase supplemental insurance.

What changes have been made for next Fiscal Year?

The management Additional Allowance will be provided to you as a stipend on a bi-weekly basis. A benefits summary form will no longer need to be signed.

The HMO Option 2 insurance plan will no longer be offered. Those employees that currently have HMO Option 2 insurance will automatically be enrolled in the HMO 1 plan.

The Long-Term Disability (LTD) buy-up rate may have changed depending if you received a salary increase since October 1, 2013. Your LTD buy-up form, showing the new bi-weekly rate, will be sent to you during the open enrollment period. Kindly sign the form and return to HR by September 12th, 2014.

If you purchase Supplemental Life Insurance, a change in rate may occur if you entered a different age bracket or increased the coverage amount.

AFLAC Flexible Spending Account (FSA): If you would like to participate in the medical reimbursement and/or dependent care reimbursement FSA next Fiscal Year, you must meet with the Aflac representative during the open enrollment period and choose the dollar amount to set aside.

How do I sign up for my benefits?

If you are not making changes to your health, dental, and/or AFLAC policies, you do not have to attend the open enrollment sessions and/or complete any additional paperwork.

If you are making changes to any of your benefits, you must attend one of the scheduled open enrollment sessions and meet with the insurance representative to complete the necessary paperwork.

What if I have questions?

Stop by any of the Open Enrollment session to speak with the representatives directly, or contact the Human Resources Department at extension 1356.

Thank you in advance for your cooperation.

- Human Resources -
What benefits am I entitled to as a Level 2 Management employee?

- 100% Paid Medical and Dental premiums for you and 90% paid premiums for your dependents.
- $1,000 additional allowance, which may be used to pay premiums or purchase supplemental insurance.

What changes have been made for next Fiscal Year?

Below is a breakdown of changes to medical and dental premiums, as well as other changes that may occur.

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>FY 14/15 Bi-Weekly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health – HMO – Option 1 – Double</td>
<td>$22.98</td>
</tr>
<tr>
<td>Health – HMO – Option 1 – Family</td>
<td>$43.59</td>
</tr>
<tr>
<td>Dental - Delta Care – Double</td>
<td>$0.41</td>
</tr>
<tr>
<td>Dental - Delta Care – Family</td>
<td>$0.92</td>
</tr>
<tr>
<td>Dental - Delta PPO – Double</td>
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<tr>
<td>Dental - Delta PPO – Family</td>
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</tr>
<tr>
<td>Vision – Single</td>
<td>$0.00</td>
</tr>
<tr>
<td>Vision – Double</td>
<td>$1.49</td>
</tr>
<tr>
<td>Vision - Family</td>
<td>$3.90</td>
</tr>
</tbody>
</table>

The management Additional Allowance will be provided to you as a stipend on a bi-weekly basis. A benefits summary form will no longer need to be signed.

The HMO Option 2 insurance plan will no longer be offered. Those employees that currently have HMO Option 2 insurance will automatically be enrolled in the HMO 1 plan.

Long-Term Disability buy-up rate may change if you received a salary increase since October 1, 2013. Your LTD buy-up form will be sent interdepartmentally. Kindly sign the form and return to HR by September 12th, 2014.

If you purchase Supplemental Life Insurance, a change in rate may occur if you entered a different age bracket or increased the coverage amount.

AFLAC Flexible Spending Account (FSA): If you would like to participate in the medical reimbursement and/or dependent care reimbursement FSA next Fiscal year, you must meet with the Aflac representative during the open enrollment period and choose the dollar amount to set aside.

How do I sign up for my benefits?

If you are not making changes to your health, dental, and/or AFLAC policies, you do not have to attend the open enrollment sessions and/or complete any additional paperwork.
If you are making changes to any of your benefits, you must attend one of the scheduled open enrollment sessions and meet with the insurance representative to complete the necessary paperwork.

What if I have questions?

Stop by any of the Open Enrollment session to speak with the representatives directly, or contact the Human Resources Department at extension 1356.

Thank you in advance for your cooperation.

- Human Resources -
2014 OPEN ENROLLMENT
LEVEL 3 MANAGEMENT BENEFITS
QUESTIONS AND ANSWERS

What benefits am I entitled to as a Level 3 Management employee?

- 100% Paid Medical and Dental premiums for you and 90% paid premiums for your dependents.
- $700 additional allowance, which may be used to pay premiums or purchase supplemental insurance.

What changes have been made for next Fiscal Year?

Below is a breakdown of changes to medical and dental premiums, as well as other changes that may occur.

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>FY 14/15 Bi-Weekly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health – HMO – Option 1 – Double</td>
<td>$22.98</td>
</tr>
<tr>
<td>Health – HMO – Option 1 – Family</td>
<td>$43.59</td>
</tr>
<tr>
<td>Dental - Delta Care – Double</td>
<td>$0.41</td>
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<tr>
<td>Dental - Delta Care – Family</td>
<td>$0.92</td>
</tr>
<tr>
<td>Dental - Delta PPO - Double</td>
<td>$3.06</td>
</tr>
<tr>
<td>Dental - Delta PPO – Family</td>
<td>$4.65</td>
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<tr>
<td>Vision – Single</td>
<td>$0.00</td>
</tr>
<tr>
<td>Vision – Double</td>
<td>$1.49</td>
</tr>
<tr>
<td>Vision - Family</td>
<td>$3.90</td>
</tr>
</tbody>
</table>

The management Additional Allowance will be provided to you as a stipend on a bi-weekly basis. A benefits summary form will no longer need to be signed.

The HMO Option 2 insurance plan will no longer be offered. Those employees that currently have HMO Option 2 insurance will automatically be enrolled in the HMO 1 plan.

Long-Term Disability buy-up rate may change if you received a salary increase since October 1, 2013. Your LTD buy-up form will be sent interdepartmentally. Kindly sign the form and return to HR by September 12th, 2014.

If you purchase Supplemental Life Insurance, a change in rate may occur if you entered a different age bracket or increased the coverage amount.

AFLAC Flexible Spending Account (FSA): If you would like to participate in the medical reimbursement and/or dependent care reimbursement FSA next Fiscal year, you must meet with the Aflac representative during the open enrollment period and choose the dollar amount to set aside.

How do I sign up for my benefits?

If you are not making changes to your health, dental, and/or AFLAC policies, you do not have to attend the open enrollment sessions and/or complete any additional paperwork.

If you are making changes to any of your benefits, you must attend one of the scheduled open enrollment sessions and meet with the insurance representative to complete the necessary paperwork.

What if I have questions?
Stop by any of the Open Enrollment session to speak with the representatives directly, or contact the Human Resources Department at extension 1356.

Thank you in advance for your cooperation.

- Human Resources -
What benefits am I entitled to as a Level 4 Management employee?

- 100% Paid HMO Option 1 Medical and Dental premiums for you and 80% paid premiums for your dependents.

What premium changes can I expect to see on my management benefit sheet?

Below is a breakdown of changes to medical and dental premiums, as well as other changes that may occur.

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<thead>
<tr>
<th>Insurance Type</th>
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</thead>
<tbody>
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<td>Health – Family</td>
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<td>$1.49</td>
</tr>
<tr>
<td>Vision - Family</td>
<td>$3.90</td>
</tr>
</tbody>
</table>

The HMO Option 2 insurance plan will no longer be offered. Those employees that currently have HMO Option 2 insurance will automatically be enrolled in the HMO 1 plan.

A benefits summary form will no longer need to be signed.

Long-Term Disability buy-up rate may change if you received a salary increase since October 1, 2013. Your LTD buy-up form will be sent interdepartmentally. Kindly sign the form and return to HR by September 12th, 2014.

If you purchase Supplemental Life Insurance, a change in rate may occur if you entered a different age bracket or increased the coverage amount.

AFLAC Flexible Spending Account (FSA): If you would like to participate in the medical reimbursement and/or dependent care reimbursement FSA next Fiscal year, you must meet with the Aflac representative during the open enrollment period and choose the dollar amount to set aside.

How do I sign up for my benefits?

If you are not making changes to your health, dental, and/or AFLAC policies, you do not have to attend the open enrollment sessions and/or complete any additional paperwork.
If you are making changes to any of your benefits, you must attend one of the scheduled open enrollment sessions and meet with the insurance representative to complete the necessary paperwork.

What if I have questions?

Stop by any of the Open Enrollment session to speak with the representatives directly, or contact the Human Resources Department at extension 1356.

Thank you in advance for your cooperation.

- Human Resources -
Important Questions | Answers | Why this Matters:
--- | --- | ---
What is the overall deductible? | $0 | See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services? | Yes, in-network hospital stay - $300 per person. There are no other specific deductibles. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses? | Yes. For in-network providers $3,000 per person / $9,000 family | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit? | Premium, balance-billed charges, prescription drug co-payments, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers? | Yes. For a list of participating providers, see [www.myCigna.com](http://www.myCigna.com) or call 1-800-Cigna24 | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist? | No. You don't need a referral to see a specialist. | You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-Cigna24 to request a copy.
- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network **providers** by charging you lower deductibles, co-payments and co-insurance amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if you use an In-Network Provider</th>
<th>Your Cost if you use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 co-pay/visit</td>
<td>Not Covered</td>
<td>----------------------none----------------------</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$45 co-pay/visit</td>
<td>Not Covered</td>
<td>----------------------none----------------------</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$45 co-pay/visit for chiropractor</td>
<td>Not Covered</td>
<td>Coverage for Spinal manipulation services and Rehabilitation services is limited to 60 days annual max.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not Covered</td>
<td>----------------------none----------------------</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Not Covered</td>
<td>----------------------none----------------------</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$75 co-pay per type of scan/day</td>
<td>Not Covered</td>
<td>----------------------none----------------------</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-Cigna24 to request a copy.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if you use an</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>In-Network Provider $0 co-pay/prescription (preventive) / $25 co-pay/prescription (retail), $25 co-pay/prescription (home delivery)</td>
<td>Out-of-Network Provider Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$45 co-pay/prescription (retail), $90 co-pay/prescription (home delivery)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$65 co-pay/prescription (retail), $130 co-pay/prescription (home delivery)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$150 co-pay/visit</td>
<td>In-network per visit co-pay is waived for non-surgical procedures</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$150 co-pay/day</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$150 co-pay/visit</td>
<td>Per visit co-pay is waived if admitted</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>-----------none-----------</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$75 co-pay/visit</td>
<td>Per visit co-pay is waived if admitted</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$150 co-pay/day</td>
<td>-----------none-----------</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at www.mycigna.com

Questions: Call 1-800-Cigna24 or visit us at www.mycigna.com.
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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if you use an In-Network Provider</th>
<th>Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$30 co-pay/office visit and $45 co-pay/other outpatient services</td>
<td>Not Covered</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health outpatient services</td>
<td>$30 co-pay/office visit and $45 co-pay/other outpatient services</td>
<td>Not Covered</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$150 co-pay/day</td>
<td>Not Covered</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$30 co-pay/office visit and $45 co-pay/other outpatient services</td>
<td>Not Covered</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$150 co-pay/day</td>
<td>Not Covered</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>Not Covered</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$150 co-pay/day</td>
<td>Not Covered</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>No charge</td>
<td>Not Covered</td>
<td>Coverage is limited to 60 days in-network annual max</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$45 co-pay/visit</td>
<td>Not Covered</td>
<td>Coverage is limited to annual max of: 60 days for Rehabilitation and Spinal manipulation services; 36 days for Cardiac rehab services</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Coverage is limited to annual max of: 60 days for Cardiac rehab services</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not Covered</td>
<td>Coverage is limited to 60 days annual max</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not Covered</td>
<td>Coverage is limited to 60 days annual max</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not Covered</td>
<td>Coverage is limited to 60 days annual max</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye Exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Coverage is limited to 60 days annual max</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Coverage is limited to 60 days annual max</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Coverage is limited to 60 days annual max</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-Cigna24 to request a copy.
## Excluded Services & Other Covered Services

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

<table>
<thead>
<tr>
<th>Not Covered</th>
<th>Not Covered</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
<td>• Habilitation services</td>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Bariatric surgery</td>
<td>• Hearing aids</td>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
<td>• Infertility treatment</td>
<td>• Weight loss programs</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
<td>• Long-term care</td>
<td></td>
</tr>
<tr>
<td>• Dental care (Children)</td>
<td>• Non-emergency care when traveling outside the U.S.</td>
<td></td>
</tr>
<tr>
<td>• Eye care (Children)</td>
<td>• Private-duty nursing</td>
<td></td>
</tr>
</tbody>
</table>

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

<table>
<thead>
<tr>
<th>Covered</th>
<th>Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Spinal manipulation services</td>
<td></td>
</tr>
</tbody>
</table>
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Florida Office of Insurance Regulation at 1-800-342-2762.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

------------------------To see examples of how this plan might cover costs for a sample medical situation, see the next page.------------------------
## Coverage Examples

### About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Note:** These numbers assume enrollment in individual-only coverage.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,610
- **Patient pays:** $930

#### Sample care costs:

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine Obstetric Care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

#### Patient pays:

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$300</td>
</tr>
<tr>
<td>Co-pays</td>
<td>$600</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$930</strong></td>
</tr>
</tbody>
</table>

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,480
- **Patient pays:** $1,920

#### Sample care costs:

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical equipment and supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office visits &amp; procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

#### Patient pays:

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Co-pays</td>
<td>$1,640</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$280</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,920</strong></td>
</tr>
</tbody>
</table>
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?
- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?
For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?
- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?
- **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?
- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?
- **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 155686  BenefitVersion: 3
Plan Name: HMO 1 FDOA2020
Kit Track: SBM10821
HP-POL/HP-APP 9/23/12
### City of Hallandale Beach
**Health/Dental/Vision Insurance Premiums**
**Effective October 1, 2015**

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Coverage Level</th>
<th>Monthly Premiums</th>
<th>Bi-Weekly Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DELTA DENTAL - PPO</strong></td>
<td>Employee</td>
<td>$35.64</td>
<td>$16.45</td>
</tr>
<tr>
<td></td>
<td>Retiree</td>
<td>$40.64</td>
<td></td>
</tr>
<tr>
<td></td>
<td>COBRA</td>
<td>$41.54</td>
<td></td>
</tr>
<tr>
<td><strong>DELTA CARE - DMO</strong></td>
<td>Employee</td>
<td>$8.88</td>
<td>$4.01</td>
</tr>
<tr>
<td></td>
<td>Retiree</td>
<td>$13.68</td>
<td></td>
</tr>
<tr>
<td></td>
<td>COBRA</td>
<td>$13.95</td>
<td></td>
</tr>
<tr>
<td><strong>CIGNA - HMO</strong></td>
<td>Employee</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>Retiree</td>
<td>$563.65</td>
<td>$574.92</td>
</tr>
<tr>
<td></td>
<td>COBRA</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emp. + 1</strong></td>
<td>Employee</td>
<td>$176.33</td>
<td>$151.71</td>
</tr>
<tr>
<td></td>
<td>Retiree</td>
<td>$1,151.43</td>
<td>$1,174.46</td>
</tr>
<tr>
<td></td>
<td>COBRA</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family (Emp. + 2 or more)</strong></td>
<td>Employee</td>
<td>$334.49</td>
<td>$1,678.60</td>
</tr>
<tr>
<td></td>
<td>Retiree</td>
<td>$1,712.17</td>
<td>$1,712.17</td>
</tr>
<tr>
<td></td>
<td>COBRA</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>UNITED HEALTH CARE - VISION</strong></td>
<td>Employee</td>
<td>$0.00</td>
<td>$3.91</td>
</tr>
<tr>
<td></td>
<td>Retiree</td>
<td>$3.99</td>
<td></td>
</tr>
<tr>
<td></td>
<td>COBRA</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emp. + 1</strong></td>
<td>Employee</td>
<td>$3.23</td>
<td>$7.14</td>
</tr>
<tr>
<td></td>
<td>Retiree</td>
<td>$7.28</td>
<td></td>
</tr>
<tr>
<td></td>
<td>COBRA</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family (Emp. + 2 or more)</strong></td>
<td>Employee</td>
<td>$8.45</td>
<td>$12.36</td>
</tr>
<tr>
<td></td>
<td>Retiree</td>
<td>$12.61</td>
<td></td>
</tr>
<tr>
<td></td>
<td>COBRA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7/21/2015
DATE: August 5, 2015

TO: City of Hallandale Beach Employees

FROM: Taren Kinglee, Human Resources Director

RE: 2015 Open Enrollment

It is Open Enrollment time for your health, dental, vision, life insurance, long term disability and flexible spending benefits!

This is the time for employees to add or drop dependents, and/or elect new coverage (except for the ICMA-Match Plan).

Choices made during Open Enrollment will remain in effect until the next plan year (September 2016) unless the employee experiences a qualifying event. For example, marriage, birth, change in number of work hours, employment termination, plan cost change, dependent becomes ineligible or loss of a spouse or other covered dependent.

The following benefit providers and costs/contributions will remain the same: Delta (dental); United (vision); AFLAC (supplemental insurances); and Minnesota Life (basic and supplemental life).

Cigna health plan costs and benefits, including rates will change as detailed in the attached Summary of Benefits and 2015 Insurance Rate Sheet. Cigna will continue to offer a nationwide Open Access plan for primary care physicians and specialists along with free gym memberships to 24 Hour Fitness and Premier Fitness.

Representatives from Cigna, Delta, United, and AFLAC will be on site from August 17th through August 21st (see attached calendar) for educational presentations, to explain changes to the plans, and to assist employees with making changes to their coverage. Questions regarding Minnesota Life should be directed to the Human Resources designee at the presentations.

Employees electing the long term disability buy-up option must sign a 2015 election form; which will be distributed separately through their department.

Employees that currently have or wish to elect Medical and/or Dependent Care Flexible Spending Accounts (FSA) must see an AFLAC representative to re-elect or add flexible spending for fiscal year 2015-16.

PARTICIPATION TO ONE OF THE OPEN ENROLLMENT SESSIONS IS MANDATORY!
All employees must attend one of the scheduled session to ask questions about the changes in health benefits, learn how to maximize their coverage and receive educational material related to preventive care/wellness.

All enrollment/change forms must be submitted to Human Resources no later than September 11, 2015. It is important that forms are returned as soon as possible to ensure new identification cards are mailed out in time for the new benefit period.

If you have questions regarding Open Enrollment, please contact Human Resources at extension 1347.

Attachments
DATE: August 5, 2015
TO: City of Hallandale Beach Retirees
FROM: Taren Kinglee, Human Resources Director
RE: 2015 Open Enrollment

It is Open Enrollment time for health, vision, dental, and life insurance benefits!

Retirees have an option to attend a presentation and visit representatives from all providers. Representatives will be available to answer questions, distribute benefit packages and assist employees and retirees with completing forms between the hours listed on the attached schedule.

Retirees DO NOT have to submit any forms unless they wish to make changes to their current coverage.

The following benefit providers and cost/contributions will remain the same: Delta (dental); United (vision); and Minnesota Life.

Cigna health plan cost and benefits, including rates will change as detailed in the attached Summary of Benefits and 2015 Insurance Rate Sheet. Cigna will continue to offer a nationwide plan with Open Access for primary care physicians and specialists along with free gym memberships to 24 Hour Fitness and Premier Fitness.

Representatives from Cigna, Delta, United, and AFLAC will be on site from August 17th through August 21st (see attached calendar) for educational presentations; to explain changes to the plans, and to assist retirees and employees with making changes to their coverage. Questions regarding Minnesota Life should be directed to the Human Resources designee at the presentations.

Although participation in Open Enrollment is not required this year unless you are making changes, it is encouraged for retirees to attend a session to ask questions about the changes in health benefits, learn how to maximize their coverage and receive educational material related to preventive care/wellness.

All enrollment/change forms must be submitted to Human Resources no later than September 11, 2015. It is important that forms are returned as soon as possible to ensure new identification cards are mailed out in time for the new benefit period.

If you have questions regarding Open Enrollment, please contact Human Resources at (954) 457-1347.

Attachments
What benefits am I entitled to as a Level 1 Management employee?

- 100% Paid Medical Insurance and Dental Insurance premiums for you and your dependents.
- $1,300 additional allowance, which may be used to purchase supplemental insurance.

What changes have been made for next Fiscal Year?

Several changes have been made to your health insurance plan. Attendance to one of the scheduled Open Enrollment sessions is mandatory for all employees.

The management Additional Allowance will continue being provided to you as a stipend on a bi-weekly basis.

The Long-Term Disability (LTD) buy-up rate may have changed depending if you received a salary increase since October 1, 2014. Your LTD buy-up form, showing the new bi-weekly rate, will be sent to you during the open enrollment period. Kindly sign the form and return to HR by September 11, 2015.

If you purchase Supplemental Life Insurance, a change in rate may occur if you entered a different age bracket or increased the coverage amount.

AFLAC Flexible Spending Account (FSA): If you would like to participate in the medical reimbursement and/or dependent care reimbursement FSA next Fiscal Year, you must meet with the Aflac representative during the open enrollment period and choose the dollar amount to set aside.

How do I sign up for my benefits?

If you are not making changes to your health, dental, and/or AFLAC policies, you still must attend one of the scheduled open enrollment sessions; however, you don’t have to complete any additional paperwork.

If you are making changes to any of your benefits, please attend one of the scheduled open enrollment sessions and meet with the insurance representative to complete the necessary paperwork.

What if I have questions?

Stop by any of the Open Enrollment session to speak with the representatives directly, or contact the Human Resources Department at extension 1356.

Thank you in advance for your cooperation.

- Human Resources -
What benefits am I entitled to as a Level 2 Management employee?

- 100% Paid Medical and Dental premiums for you and 90% paid premiums for your dependents.
- $1,000 additional allowance, which may be used to pay premiums or purchase supplemental insurance.

What changes have been made for next Fiscal Year?

Several changes have been made to your health insurance plan. Attendance to one of the scheduled Open Enrollment sessions is mandatory for all employees.

Below is a breakdown of the bi-weekly rates of your medical, dental, and vision insurance premiums, as a Level II Management employee.

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>FY 15/16 Bi-Weekly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health – HMO – Option 1 – Double</td>
<td>$27.13</td>
</tr>
<tr>
<td>Health – HMO – Option 1 – Family</td>
<td>$51.46</td>
</tr>
<tr>
<td>Dental - Delta Care – Double</td>
<td>$0.41</td>
</tr>
<tr>
<td>Dental - Delta Care – Family</td>
<td>$0.92</td>
</tr>
<tr>
<td>Dental - Delta PPO – Double</td>
<td>$3.06</td>
</tr>
<tr>
<td>Dental - Delta PPO – Family</td>
<td>$4.65</td>
</tr>
<tr>
<td>Vision – Single</td>
<td>$0.00</td>
</tr>
<tr>
<td>Vision – Double</td>
<td>$1.49</td>
</tr>
<tr>
<td>Vision - Family</td>
<td>$3.90</td>
</tr>
</tbody>
</table>

The management Additional Allowance will continue being provided to you as a stipend on a bi-weekly basis.

Long-Term Disability buy-up rate may change if you received a salary increase since October 1, 2014. Your LTD buy-up form will be sent interdepartmentally. Kindly sign the form and return to HR by September 11, 2015.

If you purchase Supplemental Life Insurance, a change in rate may occur if you entered a different age bracket or increased the coverage amount.

AFLAC Flexible Spending Account (FSA): If you would like to participate in the medical reimbursement and/or dependent care reimbursement FSA next Fiscal year, you must meet with the Aflac representative during the open enrollment period and choose the dollar amount to set aside.

How do I sign up for my benefits?

If you are not making changes to your health, dental, and/or AFLAC policies, you still must attend one of the scheduled open enrollment sessions; however, you don’t have to complete any additional paperwork.
If you **are making changes** to any of your benefits, you must attend one of the scheduled open enrollment sessions and meet with the insurance representative to complete the necessary paperwork.

**What if I have questions?**

Stop by any of the Open Enrollment session to speak with the representatives directly, or contact the Human Resources Department at extension 1356.

Thank you in advance for your cooperation.

- Human Resources -
What benefits am I entitled to as a Level 3 Management employee?

- 100% Paid Medical and Dental premiums for you and 90% paid premiums for your dependents.
- $700 additional allowance, which may be used to pay premiums or purchase supplemental insurance.

What changes have been made for next Fiscal Year?

Several changes have been made to your health insurance plan. Attendance to one of the scheduled Open Enrollment sessions is mandatory for all employees.

Below is a breakdown of the bi-weekly rates of your medical, dental, and vision insurance premiums, as a Level III Management employee.

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>FY 15/16 Bi-Weekly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health – HMO – Option 1 – Double</td>
<td>$27.13</td>
</tr>
<tr>
<td>Health – HMO – Option 1 – Family</td>
<td>$51.46</td>
</tr>
<tr>
<td>Dental - Delta Care – Double</td>
<td>$0.41</td>
</tr>
<tr>
<td>Dental - Delta Care – Family</td>
<td>$0.92</td>
</tr>
<tr>
<td>Dental - Delta PPO - Double</td>
<td>$3.06</td>
</tr>
<tr>
<td>Dental - Delta PPO – Family</td>
<td>$4.65</td>
</tr>
<tr>
<td>Vision – Single</td>
<td>$0.00</td>
</tr>
<tr>
<td>Vision – Double</td>
<td>$1.49</td>
</tr>
<tr>
<td>Vision - Family</td>
<td>$3.90</td>
</tr>
</tbody>
</table>

The management Additional Allowance will continue being provided to you as a stipend on a bi-weekly basis.

Long-Term Disability buy-up rate may change if you received a salary increase since October 1, 2014. Your LTD buy-up form will be sent interdepartmentally. Kindly sign the form and return to HR by September 11, 2015.

If you purchase Supplemental Life Insurance, a change in rate may occur if you entered a different age bracket or increased the coverage amount.

AFLAC Flexible Spending Account (FSA): If you would like to participate in the medical reimbursement and/or dependent care reimbursement FSA next Fiscal year, you must meet with the Aflac representative during the open enrollment period and choose the dollar amount to set aside.

How do I sign up for my benefits?

If you are not making changes to your health, dental, and/or AFLAC policies, you still must attend one of the scheduled open enrollment sessions; however, you don’t have to complete any additional paperwork.

If you are making changes to any of your benefits, you must attend one of the scheduled open enrollment sessions and meet with the insurance representative to complete the necessary paperwork.
What if I have questions?

Stop by any of the Open Enrollment session to speak with the representatives directly, or contact the Human Resources Department at extension 1356.

Thank you in advance for your cooperation.

- Human Resources -
2015 OPEN ENROLLMENT
LEVEL 4 MANAGEMENT BENEFITS
QUESTIONS AND ANSWERS

What benefits am I entitled to as a Level 4 Management employee?

- 100% Paid HMO Option 1 Medical and Dental premiums for you and 80% paid premiums for your dependents.

What premium changes can I expect to see on my management benefit sheet?

Several changes have been made to your health insurance plan. Attendance to one of the scheduled Open Enrollment sessions is mandatory for all employees.

Below is a breakdown of the bi-weekly rates of your medical, dental, and vision insurance premiums, as a Level IV Management employee.

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>FY 15/16 Bi-Weekly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health – Double</td>
<td>$54.26</td>
</tr>
<tr>
<td>Health – Family</td>
<td>$102.92</td>
</tr>
<tr>
<td>Dental - Delta Care – Double</td>
<td>$0.82</td>
</tr>
<tr>
<td>Dental - Delta Care – Family</td>
<td>$1.84</td>
</tr>
<tr>
<td>Dental - Delta PPO – Double</td>
<td>$6.12</td>
</tr>
<tr>
<td>Dental - Delta PPO – Family</td>
<td>$9.31</td>
</tr>
<tr>
<td>Vision – Single</td>
<td>$0.00</td>
</tr>
<tr>
<td>Vision – Double</td>
<td>$1.49</td>
</tr>
<tr>
<td>Vision - Family</td>
<td>$3.90</td>
</tr>
</tbody>
</table>

Long-Term Disability buy-up rate may change if you received a salary increase since October 1, 2014. Your LTD buy-up form will be sent interdepartmentally. Kindly sign the form and return to HR by September 11, 2015.

If you purchase Supplemental Life Insurance, a change in rate may occur if you entered a different age bracket or increased the coverage amount.

AFLAC Flexible Spending Account (FSA): If you would like to participate in the medical reimbursement and/or dependent care reimbursement FSA next Fiscal year, you must meet with the Aflac representative during the open enrollment period and choose the dollar amount to set aside.

How do I sign up for my benefits?

If you are not making changes to your health, dental, and/or AFLAC policies, you still must attend one of the scheduled open enrollment sessions; however, you don’t have to complete any additional paperwork.

If you are making changes to any of your benefits, you must attend one of the scheduled open enrollment sessions and meet with the insurance representative to complete the necessary paperwork.
What if I have questions?

Stop by any of the Open Enrollment session to speak with the representatives directly, or contact the Human Resources Department at extension 1356.

Thank you in advance for your cooperation.

- Human Resources -
SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - City of Hallandale Beach
Open Access Plus IN Plan

Selection of a Primary Care Provider - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

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

<table>
<thead>
<tr>
<th>Plan Highlights</th>
<th>In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Your plan pays 100%</td>
</tr>
</tbody>
</table>
| **Contract Year Deductible** | Individual: $1,000
Family: $3,000 |
  - After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.
  - Copays do not contribute towards your plan deductible.
Note: Services where plan deductible applies are noted with a caret (^)

| Contract Year Out-of-Pocket Maximum | Individual: $4,000
Family: $10,000 |
  - Plan deductible contributes towards your out-of-pocket maximum.
  - All copays and benefit deductibles contribute towards your out-of-pocket maximum.
  - Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.
  - After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
</tr>
</tbody>
</table>

Note: Services where plan deductible applies are noted with a caret (^)
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong> Services where plan deductible applies are noted with a caret (^)</td>
<td></td>
</tr>
<tr>
<td><strong>Physician Office Visit</strong></td>
<td>$30 Primary Care Physician (PCP) copay or $45 Specialist copay</td>
</tr>
<tr>
<td>• All services including Lab &amp; X-ray</td>
<td></td>
</tr>
<tr>
<td>• Plan pays 100% after you pay copay</td>
<td></td>
</tr>
<tr>
<td><strong>Surgery Performed in Physician's Office</strong></td>
<td>$30 PCP or $45 Specialist copay</td>
</tr>
<tr>
<td><strong>Allergy Treatment/Injections</strong></td>
<td>$30 PCP or $45 Specialist copay or actual charge (if less)</td>
</tr>
<tr>
<td><strong>Allergy Serum</strong></td>
<td>Your plan pays 100%</td>
</tr>
<tr>
<td>Dispensed by the physician in the office</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>Your plan pays 100%</td>
</tr>
<tr>
<td>• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.</td>
<td></td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>Your plan pays 100%</td>
</tr>
<tr>
<td><strong>Mammogram, PAP, and PSA Tests</strong></td>
<td>Your plan pays 100%</td>
</tr>
<tr>
<td>• Coverage includes the associated Preventive Outpatient Professional Services.</td>
<td></td>
</tr>
<tr>
<td>• Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Facility</strong></td>
<td>$150 per day copay ($750 or 5 day annual maximum), then your plan pays 100% ^</td>
</tr>
<tr>
<td><strong>Semi-Private Room:</strong> Limited to the semi-private negotiated rate</td>
<td></td>
</tr>
<tr>
<td><strong>Private Room:</strong> Limited to the semi-private negotiated rate</td>
<td></td>
</tr>
<tr>
<td><strong>Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):</strong></td>
<td>Limited to the negotiated rate</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Physician's Visit/Consultation</strong></td>
<td>Your plan pays 100% ^</td>
</tr>
<tr>
<td><strong>Inpatient Professional Services</strong></td>
<td>Your plan pays 100% ^</td>
</tr>
<tr>
<td>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Facility Services</strong></td>
<td>$150 per facility visit copay, then your plan pays 100% ^</td>
</tr>
<tr>
<td>• Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Professional Services</strong></td>
<td>Your plan pays 100% ^</td>
</tr>
<tr>
<td>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</td>
<td></td>
</tr>
</tbody>
</table>
### Short-Term Rehabilitation

**Contract Year Maximums:**
- Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Spinal Manipulation – 60 days
- Cardiac Rehabilitation - 36 days

Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.

### Other Health Care Facilities/Services

**Home Health Care**
(includes outpatient private duty nursing subject to medical necessity)
- 60 days maximum per Contract Year
- 16 hour maximum per day

**Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility**
- 60 days maximum per Contract Year

**Durable Medical Equipment**
- Unlimited maximum per Contract Year

**Breast Feeding Equipment and Supplies**
- Limited to the rental of one breast pump per birth as ordered or prescribed by a physician.
- Includes related supplies

**External Prosthetic Appliances (EPA)**
- Unlimited maximum per Contract Year

**Routine Foot Disorders**
Not Covered

Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Physician's Office</th>
<th>Independent Lab</th>
<th>Emergency Room/ Urgent Care Facility</th>
<th>Outpatient Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab and X-ray</td>
<td>$30 PCP or $45 Specialist copay</td>
<td>Plan pays 100% ^</td>
<td>Emergency Room: Plan pays 100% ^ Emergency Room: Plan pays 100% ^</td>
<td>Plan pays 100% ^</td>
</tr>
<tr>
<td>Advanced Radiology Imaging</td>
<td>$75 copay per type of scan per day</td>
<td>Not Applicable</td>
<td>Emergency Room: Plan pays 100% ^ Emergency Room: Plan pays 100% ^</td>
<td>$75 copay per type of scan per day; then plan pays 100% ^</td>
</tr>
</tbody>
</table>

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

Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Emergency Room / Urgent Care Facility</th>
<th>Outpatient Professional Services</th>
<th>*Ambulance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>$150 per visit (copay waived if admitted) (^)</td>
<td>Plan pays 100% (^)</td>
<td>Plan pays 100% (^)</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$75 per visit (copay waived if admitted)</td>
<td>Plan pays 100%</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Inpatient Hospital and Other Health Care Facilities</th>
<th>Outpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Hospice</td>
<td>Plan pays 100% (^)</td>
<td>Plan pays 100% (^)</td>
</tr>
<tr>
<td>Bereavement Counseling</td>
<td>Plan pays 100% (^)</td>
<td>Plan pays 100% (^)</td>
</tr>
<tr>
<td>Note: Services provided as part of Hospice Care Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Services where plan deductible applies are noted with a caret ((^))</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Physician's Office</th>
<th>Inpatient Facility</th>
<th>Outpatient Facility</th>
<th>Inpatient Professional Services</th>
<th>Outpatient Professional Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Abortion (Elective and non-elective procedures)</td>
<td>$30 PCP or $45 Specialist copay</td>
<td>$150 per day copay ($750 annual maximum), then plan pays 100% (^)</td>
<td>$150 per facility visit copay, then plan pays 100% (^)</td>
<td>Plan pays 100% (^)</td>
<td>Plan pays 100% (^)</td>
</tr>
<tr>
<td>Family Planning - Men's Services</td>
<td>$30 PCP or $45 Specialist copay</td>
<td>$150 per day copay ($750 annual maximum), then plan pays 100% (^)</td>
<td>$150 per facility visit copay, then plan pays 100% (^)</td>
<td>Plan pays 100% (^)</td>
<td>Plan pays 100% (^)</td>
</tr>
<tr>
<td>Includes surgical services, such as vasectomy (excludes reversals)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning - Women's Services</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>
| Includes surgical services, such as tubal ligation (excludes reversals) | Contraceptive devices as ordered or prescribed by a physician. 

Note: Services where plan deductible applies are noted with a caret (\(^\))
### Infertility
**Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Physician's Office</th>
<th>Inpatient Facility</th>
<th>Outpatient Facility</th>
<th>Inpatient Professional Services</th>
<th>Outpatient Professional Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TMJ, Surgical and Non-Surgical

Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.

Unlimited maximum per lifetime

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Inpatient Hospital Facility</th>
<th>Inpatient Professional Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lifesource Facility In-Network</td>
<td>Non-Lifesource Facility In-Network</td>
</tr>
<tr>
<td></td>
<td>Lifesource Facility In-Network</td>
<td>Non-Lifesource Facility In-Network</td>
</tr>
</tbody>
</table>

### Organ Transplants

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

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Inpatient In-Network</th>
<th>Outpatient - Physician's Office In-Network</th>
<th>Outpatient – All Other Services In-Network</th>
</tr>
</thead>
</table>

### Mental Health

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Inpatient In-Network</th>
<th>Outpatient - Physician's Office In-Network</th>
<th>Outpatient – All Other Services In-Network</th>
</tr>
</thead>
</table>

### Substance Abuse

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Inpatient In-Network</th>
<th>Outpatient - Physician's Office In-Network</th>
<th>Outpatient – All Other Services In-Network</th>
</tr>
</thead>
</table>

**Note:** Detox is covered under medical
- Unlimited maximum per Contract Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy.
### Mental Health and Substance Use Disorder Services

**Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs**  
Cigna Behavioral Advantage - Inpatient and Outpatient Management  
- Inpatient utilization review and case management  
- Outpatient utilization review and case management  
- Partial Hospitalization  
- Intensive outpatient programs  
- Changing Lives by Integrating Mind and Body Program  
- Narcotic Therapy Management  
- Complex Psychiatric Case Management

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cigna Pharmacy Plus three-tier copay plan</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| - Patient is responsible for the applicable copay based upon the tier of the dispensed medication. | Retail - 30 day supply  
Generic Preventive: You pay $0  
Generic: You pay $25  
Preferred Brand: You pay $50  
Non-Preferred Brand: You pay $70 | Not Covered |
| - Self Administered injectable drugs - excludes infertility drugs | | |
| - Oral contraceptives included | | |
| - Includes oral contraceptives - with specific products covered 100% | | |
| - Insulin, glucose test strips, lancets, insulin needles & syringes included | | |

**Pharmacy out-of-pocket maximum**  
- Applies to in-network pharmacy costs  
- Retail and Home Delivery copays apply to the Pharmacy Out-of-Pocket  
- **Individual** - $1,500  
- **Family** - $3,000

### Pharmacy Program Information

**Pharmacy Clinical Management and Prior Authorization**  
- Your plan is subject to refill-too-soon and other clinical edits as well as prior authorization requirements.  
- Plan exclusion edits are always included.  
- Additional clinical management - Enhanced package - a group of clinical medication management options that focus on various drug use management philosophies to help actively manage the pharmacy benefit include:  
  - Benefits Exclusion - prior authorization, age edits and quantity over time edits.  
  - Intensive Appropriateness of Use - duration of therapy edits, step therapy on new market entrants, and dose optimization edits.  
  - Utilization and Unit Cost Management - prior authorization, quantity limits, maximum daily dose, and step therapy for limited class(es) of specific medications.

**Prescription Drug List:**  
- Your Cigna Standard Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.

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Pharmacy Program Information

Specialty Pharmacy Management:
- Clinical Programs
  - Prior authorization is required on specialty medications but quantity limits may apply.
  - Theracare® Program
- Medication Access Option
  - Retail and/or Home Delivery

Pharmacy Cost Management Program

Step Therapy is a prior authorization program that may require you to try other medications available to treat the same condition before the "Step Therapy" medication is covered.

- All possible Step Therapy medications are identified on the Cigna prescription drug list with an "ST" suffix. To determine if a specific drug is subject to Step Therapy for your plan, please call Customer Service at the phone number listed on your ID card or visit the Prescription Drug Price Quote tool on myCigna.com.

High Blood Pressure (ACEI/ARB)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

Cholesterol Lowering (STATIN)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

Heartburn/Ulcer (PPI)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

Bladder Problems (OAB)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

Osteoporosis (Bone)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

Sleep Disorders (HYPNOTICS)
- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
## Pharmacy Program Information

- **60 Days grace period**
- **First Fill Pay and Educate included**

### Allergy (Nasal Steroids)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

### Depression (SSRI/SNRI)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

### Skin Conditions (TI)
- Generic First One Step - Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

### Mental Health (ATYPICAL PSYCHS)
- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

### Non-Narcotic Pain relievers (NSAID)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

### ADD/ADHD (ADHD)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

### Asthma (ASTHMA)
- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

### Narcotic Pain Relievers (NARCOTICS)
- Generic First One Step - Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
**Pharmacy Program Information**

- First Fill Pay and Educate included

**Additional Information**

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

<table>
<thead>
<tr>
<th>Comprehensive Oncology Program</th>
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</thead>
<tbody>
<tr>
<td>Care Management outreach</td>
</tr>
<tr>
<td>Case Management</td>
</tr>
</tbody>
</table>

Included

**Health Advisor - A**
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

Included

**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.

**Pre-Certification - Continued Stay Review - PHS+ Inpatient** - required for all inpatient admissions
In Network: Coordinated by your physician

**Pre-Certification - Continued Stay Review - PHS+ Outpatient Prior Authorization** - required for selected outpatient procedures and diagnostic testing
In Network: Coordinated by your physician

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

**Your Health First - 200**

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

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

**Holistic health support for the following chronic health conditions:**

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

### Definitions

- **Coinsurance** - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.

- **Copay** - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

- **Deductible** - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

- **Out-of-Pocket Maximum** - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.

- **Prescription Drug List** - The list of prescription brand and generic drugs covered by your pharmacy plan.

- **Transition of Care** - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

### Exclusions

**What's Not Covered (not all-inclusive):**

Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
Exclusions

- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services do not include routine patient care costs related to qualified clinical trials as described in your plan document.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an Institutional Review Board for the proposed use.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances 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.
- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmic, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, or mental retardation.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational

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### Exclusions

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.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncturist.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulæ 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 nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, email, and Internet consultations, and telemedicine.
- Massage therapy.
These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer’s insurance certificate or summary plan description – the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

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### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
</table>
| **What is the overall deductible?** | For in-network providers $1,000 person / $3,000 family  
Does not apply to in-network preventive care & immunizations, in-network office visits, prescription drugs  
Co-payments don't count toward the deductible. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. |
| **Are there other deductibles for specific services?** | No.                                                                                                                                                                                                                          | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.                                                                        |
| **Is there an out-of-pocket limit on my expenses?** | Yes. For in-network providers $4,000 person / $10,000 family  
For in-network prescription drugs - $1,500 person / $3,000 family | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premium, balance-billed charges, prescription drug co-payments, and health care this plan doesn't cover.                                                                                                                 | Even though you pay these expenses, they don't count toward the out-of-pocket limit.                                                                                                                                   |
| **Is there an overall annual limit on what the plan pays?** | No.                                                                                                                                                                                                                          | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.                                                                                      |
| **Does this plan use a network of providers?** | Yes. For a list of participating providers, see www.myCigna.com or call 1-800-Cigna24                                                                                                                                         | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist.                                                                                                                                                                           | You can see the specialist you choose without permission from this plan.                                                                                                                                               |
| **Are there services this plan doesn't cover?** | Yes.                                                                                                                                                                                                                         | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.                                                                   |
- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan’s **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network providers by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if you use an In-Network Provider</th>
<th>Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 co-pay/visit</td>
<td>Not Covered</td>
<td>——none———</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$45 co-pay/visit</td>
<td>Not Covered</td>
<td>——none———</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$45 co-pay/visit for chiropractor</td>
<td>Not Covered</td>
<td>Coverage for Chiropractic care and Rehabilitation services is limited to 60 days annual max.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge/visit</td>
<td>Not Covered</td>
<td>——none———</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Not Covered</td>
<td>——none———</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$75 co-pay per type of scan/day</td>
<td>Not Covered</td>
<td>——none———</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$0 co-pay/prescription (preventive) / $25 co-pay/prescription (retail), $25 co-pay/prescription (home delivery)</td>
<td>Not Covered</td>
<td>Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$50 co-pay/prescription (retail), $100 co-pay/prescription (home delivery)</td>
<td>Not Covered</td>
<td>Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$70 co-pay/prescription (retail), $140 co-pay/prescription (home delivery)</td>
<td>Not Covered</td>
<td>Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at www.myCigna.com.

Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-Cigna24 to request a copy.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if you use an In-Network Provider</th>
<th>Your Cost if you use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$150 co-pay/visit</td>
<td>Not Covered</td>
<td>In-network per visit co-pay is waived for non-surgical procedures</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not Covered</td>
<td>-----------none-----------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$150 co-pay/visit</td>
<td>$150 co-pay/visit</td>
<td>Per visit co-pay is waived if admitted</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
<td>-----------none-----------</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$75 co-pay/visit</td>
<td>$75 co-pay/visit</td>
<td>Per visit co-pay is waived if admitted</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$150 co-pay/day</td>
<td>Not Covered</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not Covered</td>
<td>-----------none-----------</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$45 co-pay/office visit and no charge other outpatient services</td>
<td>Not Covered</td>
<td>-----------none-----------</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$150 co-pay/day</td>
<td>Not Covered</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$45 co-pay/office visit and no charge other outpatient services</td>
<td>Not Covered</td>
<td>-----------none-----------</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$150 co-pay/day</td>
<td>Not Covered</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>Not Covered</td>
<td>-----------none-----------</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$150 co-pay/day</td>
<td>Not Covered</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-Cigna24 to request a copy.
## Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost if you use an</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$45 co-pay/visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services

#### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

#### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Spinal manipulation services
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Florida Office of Insurance Regulation at 877-693-5236.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-800-244-6224.

-----------------To see examples of how this plan might cover costs for a sample medical situation, see the next page.-----------------
# Coverage Examples

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

![Warning]

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Note:** These numbers assume enrollment in individual-only coverage.

## Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,610
- **Patient pays:** $930

### Sample care costs:

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine Obstetric Care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

### Patient pays:

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$300</td>
</tr>
<tr>
<td>Co-pays</td>
<td>$600</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$930</strong></td>
</tr>
</tbody>
</table>

## Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,480
- **Patient pays:** $1,920

### Sample care costs:

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical equipment and supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office visits &amp; procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

### Patient pays:

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Co-pays</td>
<td>$1,640</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$280</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,920</strong></td>
</tr>
</tbody>
</table>
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?
- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?
For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?
- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?
- **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?
- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?
- **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 4262905  BenefitVersion: 5
Plan Name: HMO 1 FDOA2020
Kit Track: SBM16337
HP-POL/HP-APP 9/23/12
City of Hallandale Beach

OPEN ACCESS PLUS IN-NETWORK MEDICAL BENEFITS

EFFECTIVE DATE: October 1, 2015

CN005
3337286

This document printed in September, 2015 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
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CIGNA HEALTH AND LIFE INSURANCE COMPANY
a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: City of Hallandale Beach

GROUP POLICY(S) — COVERAGE
3337286 - HMO1 OPEN ACCESS PLUS IN-NETWORK MEDICAL BENEFITS

EFFECTIVE DATE: October 1, 2015

THE BENEFITS IN THIS CERTIFICATE CONTAIN A DEDUCTIBLE PROVISION

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

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

The Schedule
The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.
Special Plan Provisions
Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

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

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

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

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

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.
Additional Programs
We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well being of our members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

Important Notices

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

Selection of a Primary Care Provider
This plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Mental Health and Substance Abuse Exclusions:**
The following exclusion is hereby deleted and no longer applies:
- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.

**Terms within the agreement:**
The term “mental retardation” within your Certificate is hereby changed to “intellectual disabilities”.

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

HC-NOT69 12-14

**Notices**

**Coverage of Dependent Children for Medical Benefits**
Your Employer is not required to pay any portion of the premium for a Dependent child after the end of the calendar year in which the Dependent child reaches age 25. Your Employer will inform you of the applicable premium contribution required by you.

HC-IMP22 04-10 V1

**How To File Your Claim**
If your plan provides coverage when care is received only from In-Network providers, you may still have Out-of-Network claims (for example, when Emergency Services are received from an Out-of-Network provider) and should follow the claim submission instructions for those claims. Claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.
You may get the required claim forms from the website listed on your identification card or by calling the toll-free number on your identification card.

**CLAIM REMINDERS**

- **BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.**

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- **BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.**

**Timely Filing of Out-of-Network Claims**

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 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.

If it was not reasonably possible to give proof in the time required, Cigna will not reduce or deny the claim for this reason if the proof is submitted as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified unless the claimant was legally incapacitated.

**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.

**Eligibility for Employee Insurance**

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 30 hours a week; and
- you pay any required contribution.

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

**Eligibility for Dependent Insurance**

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

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

**Waiting Period**

The first day of the month following 30 days from date of hire.

**Classes of Eligible Employees**

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

**Effective Date of Employee Insurance**

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

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

**Late Entrant - Employee**

You are a Late Entrant if:

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

**Dependent Insurance**

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

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included. A newborn child will be covered for the first 31 days of life even if you fail to enroll the child. If you enroll the child after the first 31 days and by the 60th day after his birth, coverage will be offered at an additional premium. Coverage for an adopted child will become effective from the date of placement in your home or from birth for the first 31 days even if you fail to enroll the child. However, if you enroll the adopted child between the 31st and 60th days after his birth or placement in your home, coverage will be offered at an additional premium.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

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

Exception for Newborns

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

If notice is given within 60 days of the birth of the child, the insurer may not deny coverage for a child due to the failure of the insured to timely notify the insurer of the birth of the child.

HC-ELG9 04-10

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.
Open Access Plus In-Network Medical Benefits

The Schedule

<table>
<thead>
<tr>
<th>For You and Your Dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Access Plus In-Network Medical Benefits provide coverage for care In-Network. To receive Open Access Plus In-Network Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.</td>
</tr>
<tr>
<td>If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Copayments/Deductibles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments are expenses to be paid by you or your Dependent for covered services. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contract Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Year means a twelve month period beginning on each 10/01.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-Pocket Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Multiple Surgical Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assistant Surgeon and Co-Surgeon Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant Surgeon</td>
</tr>
<tr>
<td>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.)</td>
</tr>
<tr>
<td>Co-Surgeon</td>
</tr>
<tr>
<td>The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.</td>
</tr>
</tbody>
</table>
### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Lifetime Maximum</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

**The Percentage of Covered Expenses the Plan Pays**

**Note:**
"No charge" means an insured person is not required to pay Coinsurance.

**100%**

<table>
<thead>
<tr>
<th>Contract Year Deductible</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$1,000 per person</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$3,000 per family</td>
</tr>
</tbody>
</table>

**Family Maximum Calculation**

**Individual Calculation:**
Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.

<table>
<thead>
<tr>
<th>Out-of-Pocket Maximum</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$4,000 per person</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$10,000 per family</td>
</tr>
</tbody>
</table>

**Family Maximum Calculation**

**Individual Calculation:**
Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.

<table>
<thead>
<tr>
<th>Physician’s Services</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>No charge after $30 per office visit copay</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visits</td>
<td>No charge after $45 per office visit copay</td>
</tr>
<tr>
<td>Consultant and Referral Physician’s Services</td>
<td></td>
</tr>
<tr>
<td>Surgery Performed in the Physician’s Office</td>
<td>No charge after the $30 PCP or $45 Specialist per office visit copay</td>
</tr>
<tr>
<td>Second Opinion Consultations (provided on a voluntary basis)</td>
<td>No charge after the $30 PCP or $45 Specialist per office visit copay</td>
</tr>
<tr>
<td>Allergy Treatment/Injections</td>
<td>No charge after either the $30 PCP or $45 Specialist per office visit copay or the actual charge, whichever is less</td>
</tr>
<tr>
<td>Allergy Serum (dispensed by the Physician in the office)</td>
<td>No charge</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Preventive Care - all ages</td>
<td>No charge</td>
</tr>
<tr>
<td>Immunizations - all ages</td>
<td>No charge</td>
</tr>
</tbody>
</table>
### BENEFIT HIGHLIGHTS

#### Mammograms, PSA, PAP Smear
- Preventive Care Related Services (i.e. “routine” services)  
  - No charge
- Diagnostic Related Services (i.e. “non-routine” services)  
  - Subject to the plan’s x-ray & lab benefit; based on place of service

#### Inpatient Hospital - Facility Services
- Semi-Private Room and Board  
  - Limited to the semi-private negotiated rate
- Private Room  
  - Limited to the negotiated rate
- Special Care Units (ICU/CCU)  
  - Limited to the negotiated rate

#### Outpatient Facility Services
- Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room  
  - $150 per visit copay, then 100% after plan deductible
  - Non-surgical treatment procedures are not subject to the facility copay/deductible.

#### Inpatient Hospital Physician’s Visits/Consultations
- 100% after plan deductible

#### Inpatient Hospital Professional Services
- Surgeon  
  - 100% after plan deductible
- Radiologist
- Pathologist
- Anesthesiologist

#### Outpatient Professional Services
- Surgeon  
  - 100% after plan deductible
- Radiologist
- Pathologist
- Anesthesiologist

### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Emergency and Urgent Care Services</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $30 PCP or $45 Specialist per office visit copay</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>No charge after $150 per visit copay* and plan deductible</td>
</tr>
<tr>
<td></td>
<td>*waived if admitted</td>
</tr>
<tr>
<td>Outpatient Professional services (radiology, pathology and UC Physician) For UC</td>
<td>No charge after plan deductible</td>
</tr>
<tr>
<td>Outpatient Professional services (radiology, pathology and ER Physician) For ER</td>
<td>No charge</td>
</tr>
<tr>
<td>Urgent Care Facility or Outpatient Facility</td>
<td>No charge after $75 per visit copay*</td>
</tr>
<tr>
<td></td>
<td>*waived if admitted</td>
</tr>
<tr>
<td>X-ray and/or Lab performed at the Emergency Room (billed by the facility as part of the ER visit)</td>
<td>No charge after plan deductible</td>
</tr>
<tr>
<td>X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit)</td>
<td>No charge</td>
</tr>
<tr>
<td>Independent x-ray and/or Lab Facility in conjunction with an ER visit</td>
<td>No charge after plan deductible</td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) For ER</td>
<td>No charge after plan deductible</td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) For UC</td>
<td>No charge</td>
</tr>
<tr>
<td>Ambulance</td>
<td>100% after plan deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Services at Other Health Care Facilities</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Contract Year Maximum: 60 days combined</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Laboratory and Radiology Services (includes pre-admission testing)</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $30 PCP or $45 Specialist per office visit copay</td>
</tr>
<tr>
<td>Outpatient Hospital Facility</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Independent X-ray and/or Lab Facility</td>
<td>100% after plan deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>The scan copay applies per type of scan per day</td>
<td>No charge after $75 scan copay</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>$150 per day copay up to 5 days, then 100% after plan deductible (Copays will not exceed $750 per Contract Year)</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>$75 scan copay, then 100% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Outpatient Short-Term Rehabilitative Therapy and Spinal Manipulation Services</strong></td>
<td>No charge after the $30 PCP or $45 Specialist per office visit copay</td>
</tr>
<tr>
<td>Contract Year Maximum:</td>
<td></td>
</tr>
<tr>
<td>60 days for all therapies combined</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td></td>
</tr>
<tr>
<td>The Short-Term Rehabilitative Therapy maximum does not apply to the treatment of</td>
<td></td>
</tr>
<tr>
<td>autism.</td>
<td></td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
</tr>
<tr>
<td>Pulmonary Rehab</td>
<td></td>
</tr>
<tr>
<td>Cognitive Therapy</td>
<td></td>
</tr>
<tr>
<td>Spinal Manipulation Services</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Cardiac Rehabilitation</strong></td>
<td>No charge after the $45 Specialist per office visit copay</td>
</tr>
<tr>
<td>Contract Year Maximum:</td>
<td></td>
</tr>
<tr>
<td>36 days</td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Contract Year Maximum:</td>
<td></td>
</tr>
<tr>
<td>60 days (includes outpatient private nursing when approved as Medically Necessary)</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td></td>
</tr>
<tr>
<td>Outpatient Services (same coinsurance level as Home Health Care)</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td><strong>Bereavement Counseling</strong></td>
<td></td>
</tr>
<tr>
<td>Services Provided as part of Hospice Care</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Services Provided by Mental Health Professional</td>
<td>Covered under Mental Health benefit</td>
</tr>
<tr>
<td><strong>Maternity Care Services</strong></td>
<td>No charge after the $30 PCP or $45 Specialist per office visit copay</td>
</tr>
<tr>
<td>Initial Visit to Confirm Pregnancy</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>All subsequent Prenatal Visits, Postnatal Visits and Physician’s Delivery Charges (i.e. global maternity fee)</td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist</td>
<td></td>
</tr>
<tr>
<td>Delivery - Facility (Inpatient Hospital, Birthing Center)</td>
<td>No charge after the $30 PCP or $45 Specialist per office visit copay</td>
</tr>
<tr>
<td>$150 per day copay up to 5 days, then 100% after plan deductible (Copays will not exceed $750 per Contract Year)</td>
<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Abortion</strong></td>
<td></td>
</tr>
<tr>
<td>Includes elective and non-elective procedures</td>
<td>No charge after the $30 PCP or $45 Specialist per office visit copay</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>$150 per day copay up to 5 days, then 100% after plan deductible (Copays will not exceed $750 per Contract Year)</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>$150 per visit copay, then 100% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td><strong>Women’s Family Planning Services</strong></td>
<td></td>
</tr>
<tr>
<td>Office Visits, Lab and Radiology Tests and Counseling</td>
<td>No charge</td>
</tr>
<tr>
<td>Note:</td>
<td></td>
</tr>
<tr>
<td>Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician’s office.</td>
<td></td>
</tr>
<tr>
<td>Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)</td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No charge</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Men’s Family Planning Services</strong></td>
<td></td>
</tr>
<tr>
<td>Office Visits, Lab and Radiology Tests and Counseling</td>
<td>No charge after the $30 PCP or $45 Specialist per office visit copay</td>
</tr>
<tr>
<td>Surgical Sterilization Procedures for Vasectomy (excludes reversals)</td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $30 PCP or $45 Specialist per office visit copay</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>$150 per day copay up to 5 days, then 100% after plan deductible (Copays will not exceed $750 per Contract Year)</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>$150 per visit copay, then 100% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100% after plan deductible</td>
</tr>
</tbody>
</table>
### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Infertility Treatment</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services Not Covered include:</td>
<td>Not Covered</td>
</tr>
<tr>
<td>- Testing performed specifically to determine the cause of infertility.</td>
<td></td>
</tr>
<tr>
<td>- Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).</td>
<td></td>
</tr>
<tr>
<td>- Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organ Transplants</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes all medically appropriate, non-experimental transplants</td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $30 PCP or $45 Specialist per office visit copay</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100% at Lifesource center after $150 per day copay up to 5 days (Copays will not exceed $750 per Contract Year), otherwise $150 per day copay up to 5 days, then 100% after plan deductible (Copays will not exceed $750 per Contract Year)</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100% at Lifesource center, otherwise 100% after plan deductible</td>
</tr>
<tr>
<td>Lifetime Travel Maximum: $10,000 per transplant</td>
<td>No charge (only available when using Lifesource facility)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Durable Medical Equipment</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Year Maximum: Unlimited</td>
<td>100% after plan deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>External Prosthetic Appliances</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Year Maximum: Unlimited</td>
<td>100% after plan deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diabetic Equipment</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Year Maximum: Unlimited</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Nutritional Evaluation</strong></td>
<td></td>
</tr>
<tr>
<td>Contract Year Maximum:</td>
<td></td>
</tr>
<tr>
<td>3 visits per person however, the 3 visit limit will not</td>
<td></td>
</tr>
<tr>
<td>apply to treatment of diabetes.</td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $30 PCP or $45 Specialist per office visit copay</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>$150 per day copay up to 5 days, then 100% after plan deductible (Copays</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>will not exceed $750 per Contract Year</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>$150 per visit copay, then 100% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td><strong>Dental Care</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to charges made for a continuous course of</td>
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<tr>
<td>dental treatment started within six months of an injury</td>
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<tr>
<td>to sound, natural teeth.</td>
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<tr>
<td>Physician’s Office Visit</td>
<td>No charge after the $30 PCP or $45 Specialist per office visit copay</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>$150 per day copay up to 5 days, then 100% after plan deductible (Copays</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>will not exceed $750 per Contract Year</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>$150 per visit copay, then 100% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td><strong>Routine Foot Disorders</strong></td>
<td>Not covered except for services associated with foot care for</td>
</tr>
<tr>
<td></td>
<td>diabetes and peripheral vascular disease when Medically Necessary.</td>
</tr>
<tr>
<td><strong>Treatment Resulting From Life Threatening Emergencies</strong></td>
<td></td>
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<tr>
<td>Medical treatment required as a result of an emergency,</td>
<td></td>
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<tr>
<td>such as a suicide attempt, will be considered a medical</td>
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<tr>
<td>expense until the medical condition is stabilized.</td>
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<tr>
<td>Once the medical condition is stabilized, whether the</td>
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<tr>
<td>treatment will be characterized as either a medical</td>
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<tr>
<td>expense or a mental health/substance abuse expense will</td>
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<tr>
<td>be determined by the utilization review Physician in</td>
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<td>accordance with the applicable mixed services claim</td>
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<td>guidelines.</td>
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<tr>
<td><strong>Mental Health</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$150 per day copay up to 5 days, then 100% after plan deductible (Copays</td>
</tr>
<tr>
<td></td>
<td>will not exceed $750 per Contract Year</td>
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<tr>
<td>Outpatient (Includes Individual, Group and Intensive</td>
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<tr>
<td>Outpatient)</td>
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<tr>
<td>Physician’s Office Visit</td>
<td>$45 per visit copay</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>100% after plan deductible</td>
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<tr>
<td><strong>Substance Abuse</strong></td>
<td></td>
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<tr>
<td>Inpatient</td>
<td>$150 per day copay up to 5 days, then 100% after plan deductible (Copays</td>
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<tr>
<td></td>
<td>will not exceed $750 per Contract Year</td>
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<tr>
<td>Outpatient (Includes Individual and Intensive Outpatient)</td>
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<tr>
<td>Physician’s Office Visit</td>
<td>$45 per visit copay</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>100% after plan deductible</td>
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</tbody>
</table>
Open Access Plus In-Network Medical Benefits

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;
- intensive outpatient programs;
- advanced radiological imaging;
- non-emergency ambulance; or
- transplant services.

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

Covered Expenses
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment, except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services 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 anesthesics 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 or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: a baseline mammogram for women ages 35 through 39; a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; a mammogram every year for women age 50 and over; and one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician’s recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.
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 diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint. Appliances and non-surgical treatment including for orthodontia are not covered.
- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.
- charges for general anesthesia and hospitalization services for dental procedures for an individual who is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.
- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.
- charges made for medical, surgical and Hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy. Services provided to you by a certified nurse-midwife or a licensed midwife, in a home setting or in a licensed birthing center. Coverage for a mother and her newborn child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. Post delivery care for a mother and her newborn shall be covered. Post delivery care includes: a postpartum assessment and newborn assessment, which can be provided at the hospital, the attending Physician’s office, and outpatient maternity center or in the home by an Other Health Care Professional trained in mother and newborn care. The services may include physical assessment of the newborn and mother, and the performance of any clinical tests and immunizations in keeping with prevailing medical standards.
- coverage for diagnosis and treatment of autism spectrum disorder to include autistic disorder, Asperger’s Syndrome and pervasive developmental disorder not otherwise specified, when prescribed by a treating Physician in accordance with a treatment plan for individuals diagnosed at age 8 or younger. Coverage is provided for Dependents to age 18, or older if attending High School. Treatment includes well-baby and well-child screening for diagnosis and treatment through speech therapy, occupational therapy, physical therapy and applied behavior analysis. Day or visit maximums applied to such treatment for other causes will not apply to treatment of autism spectrum disorder.
- charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: have vertebral abnormalities; are receiving long-term glucocorticoid (steroid) therapy; have primary hyperparathyroidism; have a family history of osteoporosis; and/or are estrogen-deficient individuals who are at clinical risk for osteoporosis.
- charges for a drug that has been prescribed for the treatment of a type of cancer for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be covered, provided: it is recognized for the treatment of the specific type of cancer for which the drug has been prescribed in one of the following reference compendia: the United States Pharmacopeia Drug Information; the American Medical Association Drug Evaluations; the American Hospital Formulary Service Drug Information; or the drug is recommended by one review article in a U.S. peer-reviewed national professional journal; it has been otherwise approved by the FDA; and its use for the specific type of cancer treatment prescribed has not been contraindicated by the FDA.
- charges made by a Physician, certified diabetes educator or licensed dietitian for a program which provides instruction on an outpatient basis for a person who has been diagnosed as having diabetes, for the purpose of instructing such person about the condition and its control;
- charges for or in connection with a bone marrow transplant when recommended by a Physician and deemed acceptable
by the appropriate oncological specialty. This treatment cannot be considered experimental under the rules of the Secretary of Health and Rehabilitative Services. Please call your Claims Office prior to receiving any treatment in order to determine your benefits.

- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be Medically Necessary by the Physician and in consultation with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.

- charges for newborn and infant hearing screening and Medically Necessary follow-up evaluations. When ordered by the treating Physician, a newborn's hearing screening must include auditory brainstem responses or evoked otocoustic emissions or other appropriate technology approved by the FDA. All screenings shall be conducted by a licensed audiologist, Physician, or supervised individual who has training specific to newborn hearing screening. Newborn means an age range from birth through 29 days. Infant means an age range from 30 days through 12 months.

In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below, for a Dependent child who is age 15 or less, for charges made for Child Preventive Care Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

- a history;
- physical examination;
- development assessment;
- anticipatory guidance; and
- appropriate immunizations and laboratory tests;
- excluding any charges for:

  - more than one visit to one provider for Child Preventive Care Services at each of the Approximate Age Intervals shown below, up to a total of 18 visits for each Dependent child;
  - services for which benefits are otherwise provided under this Covered Expenses section;
  - services for which benefits are not payable, according to the Expenses Not Covered section.

It is provided that any Deductible that would otherwise apply will be waived for those Covered Expenses incurred for Child Preventive Care Services. Approximate Age Intervals are: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years and 15 years.

Clinical Trials
Charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:

- the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
- the trial investigates a treatment for terminal cancer and: the person has failed standard therapies for the disease; cannot tolerate standard therapies for the disease; or no effective nonexperimental treatment for the disease exists;
- the person meets all inclusion criteria for the clinical trial and is not treated “off-protocol”; the trial is approved by the Institutional Review Board of the institution administering the treatment.

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed herein as Exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

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

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

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

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

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

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

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

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

**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.

**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 nonskilled 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 nonskilled 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 Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

**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.

Mental Health and Substance Abuse Services

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

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

Inpatient Mental Health Services

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

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

Mental Health Residential Treatment Services are services provided by a Hospital 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

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

Inpatient Substance Abuse Rehabilitation Services

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

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

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

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

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

Outpatient Substance Abuse Rehabilitation Services

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

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

Substance Abuse Detoxification Services

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

Exclusions

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

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

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

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appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines. Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

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

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**Prostheses/Prosthetic Appliances and Devices**

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

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

**Orthoses and Orthotic Devices**

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

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

The following are specifically excluded orthoses and orthotic devices:

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

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**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.
- 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.

**Short-Term Rehabilitative Therapy and Spinal Manipulation Care Services**

- charges made for Short-term Rehabilitative Therapy that is part of a rehabilitative program, including physical, speech, occupational, cognitive, osteopathic manipulative, and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Also included are services that are provided by a Spinal Manipulation Physician when provided in an outpatient setting. Services of a Spinal Manipulation Physician include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

The following limitation applies to Short-term Rehabilitative Therapy and Spinal Manipulation Care Services:

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

Short-term Rehabilitative Therapy and Spinal Manipulation Care 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;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrences or to maintain the patient’s current status;

The following are specifically excluded from Spinal Manipulation Care Services:

- services of a Spinal Manipulation Physician which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- vitamin therapy.

If multiple outpatient services are provided on the same day they constitute one day.

A separate Copayment will apply to the services provided by each 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 nondiseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs.
During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

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

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

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

All Transplant services, other than cornea, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® 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 not covered.

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

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

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

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

Medical Conversion Privilege
For You and Your Dependents
When a person’s Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by Cigna only to a person who:
- resides in a state that requires offering a conversion policy,
is Entitled to Convert, and
• applies in writing and pays the first premium for the
Converted Policy to Cigna within 31 days after the date his
insurance ceases. Evidence of good health is not needed.

**Employes Entitled to Convert**

You are Entitled to Convert Medical Expense Insurance for
yourself and all of your Dependents who were insured when
your insurance ceased but only if:

• you are not eligible for other individual insurance
  coverage on a guaranteed issue basis.
• you have been insured for at least three consecutive
  months under the policy or under it and a prior policy
  issued to the Policyholder.
• your insurance ceased because you were no longer in
  Active Service or no longer eligible for Medical Expense
  Insurance.
• you are not eligible for Medicare.
• you would not be Overinsured.
• you have paid all required premium or contribution.
• you have not performed an act or practice that constitutes
  fraud in connection with the coverage.
• you have not made an intentional misrepresentation of a
  material fact under the terms of the coverage.
• your insurance did not cease because the policy in its
  entirety canceled.

If you retire, you may apply for a Converted Policy within 31
days after your retirement date in place of any continuation of
your insurance that may be available under this plan when you
retire, if you are otherwise Entitled to Convert.

**Dependents Entitled to Convert**

The following Dependents are also Entitled to Convert:

• a child who is not eligible for other individual insurance
  coverage on a guaranteed issue basis, and whose
  insurance under this plan ceases because he no longer
  qualifies as a Dependent or because of your death;
• a spouse who is not eligible for other individual insurance
  coverage on a guaranteed issue basis, and whose
  insurance under this plan ceases due to divorce,
  annulment of marriage or your death;
• your Dependents whose insurance under this plan ceases
  because your insurance ceased solely because you are
  eligible for Medicare;

but only if that Dependent: is not eligible for other individual
insurance coverage on a guaranteed issue basis, is not eligible
for Medicare, would not be Overinsured, has paid all required
premium or contribution, has not performed an act or practice
that constitutes fraud in connection with the coverage, and has
not made an intentional misrepresentation of a material fact
under the terms of the coverage.

**Overinsured**

A person will be considered Overinsured if either of the
following occurs:

• his insurance under this plan is replaced by similar group
  coverage within 31 days.
• the benefits under the Converted Policy, combined with
  Similar Benefits, result in an excess of insurance based on
  Cigna's underwriting standards for individual policies.

Similar Benefits are: those for which the person is covered by
another hospital, surgical or medical expense insurance policy,
or a hospital, or medical service subscriber contract, or a
medical practice or other prepayment plan or by any other
plan or program; those for which the person is eligible,
whether or not covered, under any plan of group coverage on
an insured or uninsured basis; or those available for the person
by or through any state, provincial or federal law.

**Converted Policy**

If you reside in a state that requires the offering of a
conversion policy, the Converted Policy will be one of Cigna's
current conversion policy offerings available in the state
where you reside, as determined based upon Cigna's rules.

The Converted Policy will be issued to you if you are Entitled
to Convert, insuring you and those Dependents for whom you
may convert. If you are not Entitled to Convert and your
spouse and children are Entitled to Convert, it will be issued to
the spouse, covering all such Dependents. Otherwise, a
Converted Policy will be issued to each Dependent who is
Entitled to Convert. The Converted Policy will take effect on
the day after the person's insurance under this plan ceases. The
premium on its effective date will be based on: class of risk
and age; and benefits.

During the first 12 months the Converted Policy is in effect,
the amount payable under it will be reduced so that the total
amount payable under the Converted Policy and the Medical
Benefits Extension of this plan (if any) will not be more than
the amount that would have been payable under this plan if the
person's insurance had not ceased. After that, the amount
payable under the Converted Policy will be reduced by any
amount still payable under the Medical Benefits Extension of
this plan (if any). Cigna or the Policyholder will give you, on
request, further details of the Converted Policy.
Prescription Drug Benefits

The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

Copayments

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

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred at a Pharmacy for Prescription Drugs and Related Supplies for which no payment is provided because of the Coinsurance factor and any Copayments or Deductibles. When the Out-of-Pocket maximum shown in The Schedule is reached, benefits are payable at 100%.

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>PARTICIPATING PHARMACY</th>
<th>Non-PARTICIPATING PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Pocket Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,500 per person</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000 per family</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Retail Prescription Drugs</td>
<td>The amount you pay for each 30-day supply</td>
<td>The amount you pay for each 30-day supply</td>
</tr>
</tbody>
</table>

Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.

Tier 1

Generic* drugs on the Prescription Drug List

No charge after $25 copay

In-network coverage only

Tier 2

Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent

No charge after $50 copay

In-network coverage only

Tier 3

Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List

No charge after $70 copay

In-network coverage only

* Designated as per generally-accepted industry sources and adopted by the Insurance Company
### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Home Delivery Prescription Drugs</th>
<th>PARTICIPATING PHARMACY</th>
<th>Non-PARTICIPATING PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The amount you pay for each 90-day supply</td>
<td>The amount you pay for each 90-day supply</td>
</tr>
<tr>
<td><strong>Medications required as part of preventive care services (detailed information is available at <a href="http://www.healthcare.gov">www.healthcare.gov</a>) are covered at 100% with no copayment or deductible.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Tier 1**  
Generic* drugs on the Prescription Drug List  
No charge after $25 copay  
In-network coverage only

**Tier 2**  
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent  
No charge after $100 copay  
In-network coverage only

**Tier 3**  
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List  
No charge after $140 copay  
In-network coverage only

* Designated as per generally-accepted industry sources and adopted by the Insurance Company
Prescription Drug Benefits
For You and Your Dependents

Covered Expenses
If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

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

Limitations
Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Participating Pharmacy, unless limited by the drug manufacturer’s packaging; or
- up to a consecutive 90-day supply at a home delivery Participating Pharmacy, unless limited by the drug manufacturer’s packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

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

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

Exclusions
No payment will be made for the following expenses:

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

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

Reimbursement/Filing a Claim
When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Copayment, Coinsurance or Deductible shown in the Schedule at the time of purchase. You do not need to file a claim form unless you are unable to purchase Prescription Drugs at a Participating Pharmacy for Emergency Services.

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

See your Employer's Benefit Plan Administrator to obtain the appropriate claim form.
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 Schedule. 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.
- 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 abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section(s) of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” section(s) of this plan.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery: Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- appliances for and nonsurgical treatment of TMJ disorders.
- 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 for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- 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.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
• transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
• 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.
• nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, or mental retardation.
• therapy or treatment intended primarily to improve or maintain general physical 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.
• hearing aids, including but not limited to semi-implantable hearing devices, auditory bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
• aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
• eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
• routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
• treatment by acupuncture.
• all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
• routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
• membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
• genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
• dental implants for any condition.
• fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
• blood administration for the purpose of general improvement in physical condition.
• cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
• cosmetics, dietary supplements and health and beauty aids.
• all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
• medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
• medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
• for or in connection with an Injury or Sickness arising out
of, or in the course of, any employment for wage or profit.
• telephone, email, and Internet consultations, and
telemedicine.
• massage therapy.

**General Limitations**
No payment will be made for expenses incurred for you or any
one of your Dependents:
• for charges made by a Hospital owned or operated by or
which provides care or performs services for, the United
States Government, if such charges are directly related to a
military-service-connected Injury or Sickness.
• 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 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.

**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.
• Coverage under Medicare and other governmental benefits
as permitted by law, excepting Medicaid 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 that 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.

**Allowable Expense**
A necessary, reasonable and customary service or expense,
including deductibles, coinsurance or copayments, that is
covered in full or in part by any Plan covering you. When a
Plan provides benefits in the form of services, the Reasonable
Cash Value of each service is the Allowable Expense and is a
paid benefit.

Examples of expenses or services that are not Allowable
Expenses include, but are not limited to the following:
• An expense or service or a portion of an expense or service
that is not covered by any of the Plans is not an Allowable
Expense.
• If you are confined to a private Hospital room and no Plan
provides coverage for more than a semiprivate room, the
difference in cost between a private and semiprivate room is
not an Allowable Expense.
• If you are covered by two or more Plans that provide
services or supplies on the basis of reasonable and
customary fees, any amount in excess of the highest
reasonable and customary fee is not an Allowable Expense.
• If you are covered by one Plan that provides services or
supplies on the basis of reasonable and customary fees and
one Plan that provides services and supplies on the basis of
negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

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

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 by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

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 you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as 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.

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

Effect on the Benefits of This Plan
If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

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

- Cigna's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all
Social Security Act of 1965 as amended for the following:

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

Cigna will assume the amount payable under:

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

• Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.

• Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

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

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

Domestic Partners

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

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

• Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant," for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.

• Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement,
judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured, motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

**Subrogation/Right of Reimbursement**
If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- **Subrogation:** The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan’s subrogation rights.

- **Right of Reimbursement:** The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

**Lien of the Plan**
By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;

- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;

- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

**Additional Terms**

- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.

- The plan’s right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called “Made-Whole Doctrine”, “Rimes Doctrine”, or any other such doctrine purporting to defeat the plan’s recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan’s rights hereunder, specifically; no court costs, attorneys’ fees or other representatives’ fees may be deducted from the plan’s recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called “Fund Doctrine”, “Common Fund Doctrine”, or “Attorney’s Fund Doctrine”.

- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.

- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney’s fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
Payment of Benefits

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

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

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

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

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

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

Calculation of Covered Expenses
Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:
• the methodologies in the most recent edition of the Current Procedural terminology,
• the methodologies as reported by generally recognized professionals or publications.

Termination of Insurance

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

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

Temporary Layoff or Leave of Absence
If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date as determined by your Employer.

Injury or Sickness
If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness for a period not longer than 12 months.

Retirement
If your Active Service ends because you retire, your insurance will be continued until the date as determined by your Employer.

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.
Special Continuation of Medical Insurance For Dependents of Military Reservists

If your insurance ceases because you are called to active military duty in: the Florida National Guard; or the United States military reserves, you may elect to continue Dependent insurance. You must pay the required premiums to the Policyholder if you choose to continue Dependent insurance. In no event will coverage be continued beyond the earliest of the following dates:

- the expiration of 30 days from the date the Employee's military service ends;
- the last day for which the required contribution for Dependent insurance has been made;
- the date the Dependent becomes eligible for insurance under another group policy. Coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is excluded from this provision;
- the date the Dependent becomes eligible for Medicare;
- the date the group policy cancels;
- the date the Dependent ceases to be an eligible Dependent.

Reinstatement of Medical Insurance - Employees and Dependents

Upon completion of your active military duty in: the Florida National Guard; or the United States military reserves, you are entitled to the reinstatement of your insurance and that of your Dependents if continuation of Dependent insurance was not elected. Such reinstatement will be without the application of: any new waiting periods; or the Pre-existing Condition Limitation to any new condition that you or your Dependent may have developed during the period that coverage was interrupted due to active military duty.

Provisions Applicable to Reinstatement

- You must notify your Employer, before reporting for military duty, that you intend to return to Active Service with that Employer; and
- You must notify your Employer that you elect such reinstatement within 30 days after returning to Active Service with that Employer and pay any required premium.

Conversion Available Following Continuation

The provisions of the "Medical Conversion Privilege" section will apply when the insurance ceases.

Rescissions

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

Medical Benefits Extension Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury, Sickness or pregnancy, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury, Sickness or pregnancy. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date a succeeding carrier agrees to provide coverage without limitation for the disabling condition;
- the date you are no longer Totally Disabled;
- 12 months from the date the policy is canceled; or
- for pregnancy, until delivery.

Totally Disabled

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

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

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

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

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

Notice of Provider Directory/Networks

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

If your Plan utilizes a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are employed by or contracted with Cigna HealthCare.

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

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

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

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

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

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

- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee’s or Dependent’s other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).

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

- **Eligibility for employment assistance under State Medicaid or Children’s Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.
Effect of Section 125 Tax Regulations on This Plan

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

A. Coverage Elections
Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through H.

B. Change of Status
A change in status is defined as:

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

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

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

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

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

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

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

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

Eligibility for Coverage for Adopted Children
Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child’s adoption.
If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

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

Coverage for Maternity Hospital Stay
Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

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

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

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

Continuation of Health Insurance During Leave
Your health insurance will be continued during a leave of absence if:
- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.
The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave
Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.
You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

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

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

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

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

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

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

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

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

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

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

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

Claim Determination Procedures
The following complies with federal law. Provisions of the laws of your state may supersede.

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

Certain services require prior authorization in order to be covered. This prior authorization is called a “preservice Medical Necessity determination.” The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider’s network participation documents as applicable.

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

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

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna’s Physician will defer to the determination of the treating Physician, regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

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

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

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

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

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

Notice of Adverse Determination
Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan’s review procedures and the time limits applicable, including a statement of a claimant’s rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.
COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

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

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

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

Who is Entitled to COBRA Continuation?

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

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

Secondary Qualifying Events

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

Disability Extension

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

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

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

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

All causes for “Termination of COBRA Continuation” listed below will also apply to the period of disability extension.
Medicare Extension for Your Dependents
When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

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

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

Moving Out of Employer’s Service Area or Elimination of a Service Area
If you and/or your Dependents move out of the Employer’s service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to emergency services only. Because the Plan does not provide out-of-network coverage, nonemergency services will not be covered under the plan outside of the Employer’s service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

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

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

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

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

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

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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

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

Grace periods for subsequent payments

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

You Must Give Notice of Certain Qualifying Events

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

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

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

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

Newly Acquired Dependents

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

COBRA Continuation for Retirees Following Employer’s Bankruptcy

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

**Conversion Available Following Continuation**

If your or your Dependents’ COBRA continuation ends due to the expiration of the maximum 18-, 29- or 36-month period, whichever applies, you and/or your Dependents may be entitled to convert to the coverage in accordance with the Medical Conversion benefit then available to Employees and the Dependents. Please refer to the section titled “Conversion Privilege” for more information.

**Interaction With Other Continuation Benefits**

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

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**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:

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

Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:
- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual’s state of residence.

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**Notice of an Appeal or a Grievance**

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

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**When You Have A Complaint Or An Appeal**

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.
We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Customer Service
We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call, or write to us at the following:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure
Cigna has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Cigna has a single level appeals procedure for Florida Adverse Determination appeals which are Medical Necessity appeals received in writing within 30 calendar days of the initial Medical Necessity denial. Cigna has a two step appeals procedure for the appeal of coverage decisions which are not Florida Adverse Determinations. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal
Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level one appeal would be detrimental to your medical condition.

Cigna’s Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal
If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

If the appeal involves a coverage decision based on issues of Medical Necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician Reviewer in the same or similar specialty as the care under consideration, as determined by Cigna’s Physician Reviewer. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was not involved in any previous decision related to your appeal, and not a subordinate of previous decision makers. Provide all relevant documentation with your second-level appeal request.

For required preservice and concurrent care coverage determinations, Cigna’s review will be completed within 15 calendar days. For postservice claims, Cigna’s review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the...
rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the decision within five working days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna’s Physician Reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

**Independent Review Procedure**

If you are not fully satisfied with the decision of Cigna’s level two appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna’s level two appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if a delay would be detrimental to your condition, as determined by Cigna’s Physician Reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from the facility, the review shall be completed within 72 hours.

**Florida Adverse Determination Medical Necessity Appeal**

To initiate an Adverse Determination appeal, you must submit a request in writing to Cigna within 30 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable to write, you may ask Cigna to assist so that you may register your written appeal. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Your appeal will be reviewed and the decision made by individuals not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by an Internal Panel of health care professionals. For appeals involving Medical Necessity or clinical appropriateness, the Internal Panel will include at least one Physician in the same or similar specialty as the care under consideration, as determined by the Cigna Physician Reviewer.

For Adverse Determination Medical Necessity Appeals, we will acknowledge in writing that we have received your request and schedule a panel review. For preservice and concurrent care coverage determinations, the panel review will be completed within 30 calendar days and for postservice claims, the panel review will be completed within 60 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Internal Panel to complete the review.

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

You will be notified in writing of the Internal Panel's decision within five working days after the panel considers your request.

You may request that the appeal process be expedited if: (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited Medical Necessity appeal would be detrimental to your medical condition.

The Cigna Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.
Appeal to the State of Florida
You have the right to contact the state regulators for assistance at any time. The state regulators may be contacted at the following addresses and telephone numbers:

- The Agency for Health Care Administration
  Fort Knox Building One, Room 339
  2727 Mahan Drive
  Tallahassee, FL 32308
  1-888-419-3456

- Florida Office of Insurance Regulation
  200 East Gaines St.
  Tallahassee, FL 32399-0300
  1-800-342-2762

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

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

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

Legal Action
If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action. However, no action will be brought at all unless brought within five years after proof of claim is required under the Plan. However, no action will be brought at all unless brought within five years after a claim is submitted for In-Network services.

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

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

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.

Dependent
Dependents are:
- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is:
  - less than 26 years old.
  - from 26 years until the end of the calendar year in which the child reaches the age of 30, provided the child is unmarried and does not have a dependent of his own, is a Florida state resident or a full-time or part-time student, and is not covered under a plan of his own or entitled to benefits under Title XVIII of the Social Security Act.
- who is 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence is not required to be submitted to Cigna as a condition of coverage after the date the child ceases to qualify above. However, if a claim is denied, proof must be submitted by the Employee that the child is and has continued to be mentally or physically handicapped.

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. A child also includes a foster child or a child placed in your custody by a court order from the date of placement in the home. Coverage is not required if the adopted or foster child is ultimately not placed in your home. It also includes:
- a stepchild or a child for whom you are the legal guardian;
- a child born to an insured Dependent child of yours until such child is 18 months old.

If your Domestic Partner has a child, that child will also be included as a Dependent.

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

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

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

Domestic Partner
A Domestic Partner is defined as a person of the same or opposite sex who:
- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank
account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;

- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

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

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

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

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

**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.

**Employee**
The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

**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.

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 Ambulatory Surgical Center; or
- an institution which: specializes in treatment of Mental Health and Substance Abuse or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

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

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

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

**Medically Necessary/Medical Necessity**

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

**Injury**

The term Injury means an accidental bodily injury.

**Maximum Reimbursable Charge - Medical**

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

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

The percentile used to determine the Maximum Reimbursable Charge can be obtained by contacting Member Services/Customer Service.

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.

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

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

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

Prescription Drug List
Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

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

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.

Related Supplies
Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

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

Spinal Manipulation Care
The term Spinal Manipulation 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.

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.

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.
<table>
<thead>
<tr>
<th></th>
<th>DELTA CARE - DMO</th>
<th>DELTA DENTAL - PPO</th>
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<tr>
<td><strong>Employee</strong></td>
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<td>per mth</td>
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<table>
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<td>per mth</td>
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<td>semi-monthly</td>
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<td><strong>Retiree</strong></td>
</tr>
<tr>
<td>per mth</td>
<td>$0.00</td>
</tr>
<tr>
<td>semi-monthly</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>Emp + 1</strong></td>
<td><strong>per mth</strong></td>
</tr>
<tr>
<td>per mth</td>
<td>$3.23</td>
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<tr>
<td>semi-monthly</td>
<td>$1.62</td>
</tr>
<tr>
<td><strong>Family (Emp. + 2 or more)</strong></td>
<td><strong>per mth</strong></td>
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<tr>
<td>per mth</td>
<td>$8.45</td>
</tr>
<tr>
<td>semi-monthly</td>
<td>$4.23</td>
</tr>
</tbody>
</table>
DATE: August 15, 2016

TO: City of Hallandale Beach Employees

FROM: Taren Kinglee, Human Resources Director

RE: 2016 Open Enrollment

It is Open Enrollment time for your health, dental, vision, life insurance, long term disability and flexible spending benefits!

- **This year, the City has chosen an online enrollment system through Choicelinx Benefit Administration. You are able to go online to make your benefits selection, add, remove or change your current plan enrollment. Attached you will find step by step instructions on how to log in to:** [www.benefitsinsight.com](http://www.benefitsinsight.com)

This is the time for employees to add or drop dependents, and/or elect new coverage (except for the ICMA-Match Plan).

Choices made during Open Enrollment will remain in effect until the next plan year (September 2017) **unless** the employee experiences a qualifying event. For example: marriage, birth, change in number of work hours, employment termination, dependent gain/loss of insurance coverage or loss of a spouse or other covered dependent.

- **The following benefit providers and costs/contributions will remain the same: Delta (dental); United (vision); AFLAC (supplemental insurances); However, payroll deductions will be semi-monthly for all benefits except for Minnesota Life (basic and supplemental life), which is once a month.**

Cigna’s health insurance plan costs will increase as detailed in the attached 2016 Insurance Rate Sheet. The health benefit coverage will remain the same, including a nationwide Open Access plan for primary care physicians and specialists as detailed in the attached Summary of Benefits and Coverage (SBC).

Representatives from Cigna, Delta, United, and AFLAC will be on site from **August 22<sup>nd</sup> through August 26<sup>th</sup>** (see attached calendar) for online enrollment assistance, educational presentations, and to assist employees with making changes to their coverage. Questions regarding Minnesota Life should be directed to the Human Resources designee at the presentations.

- **Employees that currently have or wish to elect Medical and/or Dependent Care Flexible Spending Accounts (FSA) must re-elect or add flexible spending for fiscal year 2016-17 on the Choicelinx online enrollment platform. You will also elect your long term disability buy-up option online.**

If you would like assistance for the online platform, please enroll yourself to a session as spaces are limited to accommodate 24 employees per session [https://cohb.formstack.com/forms/2016_open_enrollment](https://cohb.formstack.com/forms/2016_open_enrollment)

**ONLINE ENROLLMENT REGISTRATION IS MANDATORY TO CONFIRM YOUR BENEFITS!! HOWEVER, PARTICIPATION TO ONE OF THE OPEN ENROLLMENT SESSIONS IS OPTIONAL!** All employees must log in to Choicelinx to confirm, enroll and/or make selection to their current benefits.

- **All enrollment/change request must be submitted to Human Resources through Choicelinx no later than September 9, 2016. If you have questions regarding Open Enrollment, please contact Human Resources at extension 1347.**

Attachments
What benefits am I entitled to as a Level 1 Management employee?

- 100% Paid Medical Insurance and Dental Insurance premiums for you and your dependents.
- $1,300 additional allowance, which may be used to purchase supplemental insurance.

What changes have been made for next Fiscal Year?

This year, the City has chosen an online enrollment system through Choicelinx Benefit Administration. You are able to go online to make your benefits selection, add, remove or change your current plan enrollment. Attached you will find step by step instructions on how to log in to: www.benefitsinsight.com

There are no changes to your health insurance plan. Attendance to one of the scheduled Open Enrollment sessions is voluntary for all employees.

Beginning October 1, 2016, all insurance premiums will be deducted bi-monthly instead of bi-weekly; therefore, employees will have 24 insurance deductions versus 26. This change applies only to insurance deductions.

The management Additional Allowance will continue being provided to you as a stipend on a bi-weekly basis.

The Long-Term Disability (LTD) buy-up rate may have changed depending if you received a salary increase since October 1, 2015.

If you purchase Supplemental Life Insurance, a change in rate may occur if you entered a different age bracket or increased the coverage amount.

AFLAC Flexible Spending Account (FSA): If you would like to participate in the medical reimbursement and/or dependent care reimbursement FSA next Fiscal Year, you must meet with the Aflac representative during the open enrollment period and choose the dollar amount to set aside.

What if I have questions?

Stop by any of the Open Enrollment session to speak with the representatives directly, or contact the Human Resources Department at extension 1356.

Thank you in advance for your cooperation.

- Human Resources -
What benefits am I entitled to as a Level 2 Management employee?

- 100% Paid Medical and Dental premiums for you and 90% paid premiums for your dependents.
- $1,000 additional allowance, which may be used to pay premiums or purchase supplemental insurance.

What changes have been made for next Fiscal Year?

This year, the City has chosen an online enrollment system through Choicelinx Benefit Administration. You are able to go online to make your benefits selection, add, remove or change your current plan enrollment. Attached you will find step by step instructions on how to log in to: www.benefitsinsight.com

There are no changes to your health insurance plan. Attendance to one of the scheduled Open Enrollment sessions is voluntary for all employees.

Beginning October 1, 2016, all insurance premiums will be deducted bi-monthly instead of bi-weekly; therefore, employees will have 24 insurance deductions versus 26. This change applies only to insurance deductions.

Below is a breakdown of the bi-monthly rates of your medical, dental, and vision insurance premiums, as a Level II Management employee.

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>FY 16/17 Bi-Monthly Premium</th>
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</thead>
<tbody>
<tr>
<td>Health – HMO – Double</td>
<td>$33.05</td>
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<tr>
<td>Health – HMO – Family</td>
<td>$62.69</td>
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<tr>
<td>Dental - Delta Care – Double</td>
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<tr>
<td>Dental - Delta Care – Family</td>
<td>$1.00</td>
</tr>
<tr>
<td>Dental - Delta PPO – Double</td>
<td>$3.32</td>
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<td>Dental - Delta PPO – Family</td>
<td>$5.04</td>
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<tr>
<td>Vision – Single</td>
<td>$0.00</td>
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<td>Vision – Double</td>
<td>$1.62</td>
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<tr>
<td>Vision - Family</td>
<td>$4.23</td>
</tr>
</tbody>
</table>

The management Additional Allowance will continue being provided to you as a stipend on a bi-weekly basis.

Long-Term Disability buy-up rate may change if you received a salary increase since October 1, 2015.

If you purchase Supplemental Life Insurance, a change in rate may occur if you entered a different age bracket or increased the coverage amount.

AFLAC Flexible Spending Account (FSA): If you would like to participate in the medical reimbursement and/or dependent care reimbursement FSA next Fiscal year, you must meet with the Aflac representative during the open enrollment period and choose the dollar amount to set aside.
What if I have questions?

Stop by any of the Open Enrollment session to speak with the representatives directly, or contact the Human Resources Department at extension 1356.

Thank you in advance for your cooperation.

- Human Resources -
What benefits am I entitled to as a Level 3 Management employee?

- 100% Paid Medical and Dental premiums for you and 90% paid premiums for your dependents.
- $700 additional allowance, which may be used to pay premiums or purchase supplemental insurance.

What changes have been made for next Fiscal Year?

This year, the City has chosen an online enrollment system through Choicelinx Benefit Administration. You are able to go online to make your benefits selection, add, remove or change your current plan enrollment. Attached you will find step by step instructions on how to log in to:
www.benefitsinsight.com

There are no changes to your health insurance plan. Attendance to one of the scheduled Open Enrollment sessions is voluntary for all employees.

Beginning October 1, 2016, all insurance premiums will be deducted bi-monthly instead of bi-weekly; therefore, employees will have 24 insurance deductions versus 26. This change applies only to insurance deductions.

Below is a breakdown of the bi-monthly rates of your medical, dental, and vision insurance premiums, as a Level III Management employee.

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>FY 16/17 Bi-Monthly Premium</th>
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</thead>
<tbody>
<tr>
<td>Health – HMO – Option 1 – Double</td>
<td>$33.05</td>
</tr>
<tr>
<td>Health – HMO – Option 1 – Family</td>
<td>$62.69</td>
</tr>
<tr>
<td>Dental - Delta Care – Double</td>
<td>$0.45</td>
</tr>
<tr>
<td>Dental - Delta Care – Family</td>
<td>$1.00</td>
</tr>
<tr>
<td>Dental - Delta PPO - Double</td>
<td>$3.32</td>
</tr>
<tr>
<td>Dental - Delta PPO – Family</td>
<td>$5.04</td>
</tr>
<tr>
<td>Vision – Single</td>
<td>$0.00</td>
</tr>
<tr>
<td>Vision – Double</td>
<td>$1.62</td>
</tr>
<tr>
<td>Vision - Family</td>
<td>$4.23</td>
</tr>
</tbody>
</table>

The management Additional Allowance will continue being provided to you as a stipend on a bi-weekly basis.

Long-Term Disability buy-up rate may change if you received a salary increase since October 1, 2015.

If you purchase Supplemental Life Insurance, a change in rate may occur if you entered a different age bracket or increased the coverage amount.

AFLAC Flexible Spending Account (FSA): If you would like to participate in the medical reimbursement and/or dependent care reimbursement FSA next Fiscal year, you must meet with the Aflac representative during the open enrollment period and choose the dollar amount to set aside.
What if I have questions?

Stop by any of the Open Enrollment session to speak with the representatives directly, or contact the Human Resources Department at extension 1356.

Thank you in advance for your cooperation.
- Human Resources -
What benefits am I entitled to as a Level 4 Management employee?

- 100% Paid Medical and Dental premiums for you and 80% paid premiums for your dependents.

What premium changes can I expect to see on my management benefit sheet?

*This year, the City has chosen an online enrollment system through Choicelinx Benefit Administration. You are able to go online to make your benefits selection, add, remove or change your current plan enrollment. Attached you will find step by step instructions on how to log in to: www.benefitsinsight.com*

There are no changes to your health insurance plan. Attendance to one of the scheduled Open Enrollment sessions is voluntary for all employees.

Beginning October 1, 2016, all insurance premiums will be deducted bi-monthly instead of bi-weekly; therefore, employees will have 24 insurance deductions versus 26. This change applies only to insurance deductions.

Below is a breakdown of the bi-monthly rates of your medical, dental, and vision insurance premiums, as a Level IV Management employee.

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>FY 16/17 Bi-Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health – Double</td>
<td>$66.10</td>
</tr>
<tr>
<td>Health – Family</td>
<td>$125.38</td>
</tr>
<tr>
<td>Dental - Delta Care – Double</td>
<td>$0.89</td>
</tr>
<tr>
<td>Dental - Delta Care – Family</td>
<td>$2.00</td>
</tr>
<tr>
<td>Dental - Delta PPO – Double</td>
<td>$6.63</td>
</tr>
<tr>
<td>Dental - Delta PPO – Family</td>
<td>$10.09</td>
</tr>
<tr>
<td>Vision – Single</td>
<td>$0.00</td>
</tr>
<tr>
<td>Vision – Double</td>
<td>$1.62</td>
</tr>
<tr>
<td>Vision - Family</td>
<td>$4.23</td>
</tr>
</tbody>
</table>

**Long-Term Disability buy-up** rate may change if you received a salary increase since October 1, 2015.

If you purchase **Supplemental Life Insurance**, a change in rate may occur if you entered a deferent age bracket or increased the coverage amount.

**AFLAC Flexible Spending Account (FSA):** If you would like to participate in the medical reimbursement and/or dependent care reimbursement FSA next Fiscal year, you must meet with the Aflac representative during the open enrollment period and choose the dollar amount to set aside.
What if I have questions?

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Thank you in advance for your cooperation.

- Human Resources -
SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - City of Hallandale Beach
Open Access Plus IN Plan

Selection of a Primary Care Provider - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

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

Plan Highlights

<table>
<thead>
<tr>
<th>Lifetime Maximum</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coinsurance</td>
<td>Your plan pays 100%</td>
</tr>
</tbody>
</table>

Contract Year Deductible

- Individual: $1,000
- Family: $3,000

- After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.
- Copays do not contribute towards your plan deductible

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

Contract Year Out-of-Pocket Maximum

- Individual: $4,000
- Family: $10,000

- Plan deductible contributes towards your out-of-pocket maximum.
- All copays and benefit deductibles contribute towards your out-of-pocket maximum.
- Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visit</td>
<td>$30 Primary Care Physician (PCP) copay or $45 Specialist copay</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery Performed in Physician's Office</td>
<td>$30 PCP or $45 Specialist copay</td>
</tr>
<tr>
<td>Allergy Treatment/Injections</td>
<td>$30 PCP or $45 Specialist copay or actual charge (if less)</td>
</tr>
<tr>
<td>Allergy Serum</td>
<td>Your plan pays 100%</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Your plan pays 100%</td>
</tr>
<tr>
<td></td>
<td>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Your plan pays 100%</td>
</tr>
<tr>
<td>Mammogram, PAP, and PSA Tests</td>
<td>Your plan pays 100%</td>
</tr>
<tr>
<td></td>
<td>Coverage includes the associated Preventive Outpatient Professional Services.</td>
</tr>
<tr>
<td></td>
<td>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Facility</td>
<td>$150 per day copay ($750 or 5 day annual maximum), then your plan pays 100%</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-Private Room: Limited to the semi-private negotiated rate</td>
<td></td>
</tr>
<tr>
<td>Private Room: Limited to the semi-private negotiated rate</td>
<td></td>
</tr>
<tr>
<td>Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):</td>
<td>Limited to the negotiated rate</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Physician's Visit/Consultation</strong></td>
<td>Your plan pays 100% ^</td>
</tr>
<tr>
<td><strong>Inpatient Professional Services</strong></td>
<td>Your plan pays 100% ^</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>$150 per facility visit copay, then your plan pays 100% ^</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>Your plan pays 100% ^</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Short-Term Rehabilitation</strong></td>
<td>$30 PCP or $45 Specialist copay</td>
</tr>
<tr>
<td>Contract Year Maximums:</td>
<td></td>
</tr>
<tr>
<td>• Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Spinal Manipulation – 60 days</td>
<td></td>
</tr>
<tr>
<td>• Cardiac Rehabilitation - 36 days</td>
<td></td>
</tr>
<tr>
<td>Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.</td>
<td></td>
</tr>
</tbody>
</table>

**Other Health Care Facilities/Services**

| Home Health Care (includes outpatient private duty nursing subject to medical necessity) | Your plan pays 100% ^ |
| 60 days maximum per Contract Year                                                   |                                                                           |
| 16 hour maximum per day                                                             |                                                                           |

| Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility | Your plan pays 100% ^ |
| 60 days maximum per Contract Year                                                  |                                                                           |

| Durable Medical Equipment                                                          | Your plan pays 100% ^ |
| Unlimited maximum per Contract Year                                                 |                                                                           |

| Breast Feeding Equipment and Supplies                                              | Your plan pays 100% |
| Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. |
| Includes related supplies                                                            |                                                                           |

| External Prosthetic Appliances (EPA)                                               | Your plan pays 100% ^ |
| Unlimited maximum per Contract Year                                                 |                                                                           |

| Routine Foot Disorders                                                             | Not Covered |
| Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary. |

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Physician's Office</th>
<th>Independent Lab</th>
<th>Emergency Room/ Urgent Care Facility</th>
<th>Outpatient Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab and X-ray</td>
<td>$30 PCP or $45 Specialist copay</td>
<td>Plan pays 100% ^</td>
<td>Emergency Room: Plan pays 100% ^</td>
<td>Plan pays 100% ^</td>
</tr>
<tr>
<td>Advanced Radiology Imaging</td>
<td>$75 copay per type of scan per day</td>
<td>Not Applicable</td>
<td>Urgent Care: Plan pays 100%</td>
<td>Emergency Room: Plan pays 100% ^</td>
</tr>
</tbody>
</table>
### Place of Service - your plan pays based on where you receive services

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Physician’s Office</th>
<th>Independent Lab</th>
<th>Emergency Room/ Urgent Care Facility</th>
<th>Outpatient Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Emergency Room / Urgent Care Facility</th>
<th>Outpatient Professional Services</th>
<th>*Ambulance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
</tbody>
</table>

Note: Services provided as part of Hospice Care Program.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Inpatient Hospital and Other Health Care Facilities</th>
<th>Outpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Initial Visit to Confirm Pregnancy</th>
<th>Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician’s Delivery Charges)</th>
<th>Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)</th>
<th>Delivery - Facility (Inpatient Hospital, Birthing Center)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Physician's Office</th>
<th>Inpatient Facility</th>
<th>Outpatient Facility</th>
<th>Inpatient Professional Services</th>
<th>Outpatient Professional Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
</tbody>
</table>

Abortion (Elective and non-elective procedures)

$30 PCP or $45 Specialist copay

$150 per day copay ($750 or 5 day annual maximum), then plan pays 100%

$150 per facility visit copay, then plan pays 100%

Plan pays 100%

Plan pays 100%

Family Planning - Men’s Services

$30 PCP or $45 Specialist copay

$150 per day copay ($750 or 5 day annual maximum), then plan pays 100%

$150 per facility visit copay, then plan pays 100%

Plan pays 100%

Plan pays 100%
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Physician's Office</th>
<th>Inpatient Facility</th>
<th>Outpatient Facility</th>
<th>Inpatient Professional Services</th>
<th>Outpatient Professional Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
</tbody>
</table>

Includes surgical services, such as vasectomy (excludes reversals)

**Family Planning - Women's Services**
- Plan pays 100%
- Plan pays 100%
- Plan pays 100%
- Plan pays 100%
- Plan pays 100%

Includes surgical services, such as tubal ligation (excludes reversals)

**Contraceptive devices as ordered or prescribed by a physician.**

**Infertility**

*Note:* Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.

**TMJ, Surgical and Non-Surgical**
- $30 PCP or $45 Specialist copay
- $150 per day copay ($750 or 5 day annual maximum), then plan pays 100% 
- $150 per facility visit copay, then plan pays 100% 
- Plan pays 100% 
- Plan pays 100% 

Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.

**Unlimited maximum per lifetime**

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Inpatient Hospital Facility</th>
<th>Inpatient Professional Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lifesource Facility</td>
<td>Lifesource Facility</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>$150 per day copay ($750 or 5 day annual maximum)</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td></td>
<td>Non-Lifesource Facility</td>
<td>Non-Lifesource Facility</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td></td>
<td>$150 per day copay ($750 or 5 day annual maximum), then plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Inpatient</th>
<th>Outpatient - Physician's Office</th>
<th>Outpatient – All Other Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Mental Health</td>
<td>$150 per day copay ($750 or 5 day annual maximum), then plan pays 100%</td>
<td>$45 copay</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>$150 per day copay ($750 or 5 day annual maximum), then plan pays 100%</td>
<td>$45 copay</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>

*Note: Services where plan deductible applies are noted with a caret (^)*
**Note:** Detox is covered under medical
- Unlimited maximum per Contract Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy.

### Mental Health and Substance Use Disorder Services

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

- Cigna Total Behavioral Health - Inpatient and Outpatient Management
- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Narcotic Therapy Management
- Complex Psychiatric Case Management

### Pharmacy

**Cigna Pharmacy Plus three-tier copay plan**

- Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation.
- Patient is responsible for the applicable copay based upon the tier of the dispensed medication.
- Self Administered injectable drugs - excludes infertility drugs
- Oral contraceptives included
- Includes oral contraceptives - with specific products covered 100%
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges included
- Specialty medications are limited to a 30-day supply at Retail
- Specialty medications are limited to a 90-day supply at Home Delivery

#### Retail - 30 day supply
- **Generic Preventive:** You pay $0
- **Generic:** You pay $25
- **Preferred Brand:** You pay $50
- **Non-Preferred Brand:** You pay $70

#### Home delivery - 90 day supply
- **Generic Preventive:** You pay $0
- **Generic:** You pay $25
- **Preferred Brand:** You pay $100
- **Non-Preferred Brand:** You pay $140

#### Out-of-Network
- You pay 40%
- Your plan pays 60%

**Pharmacy out-of-pocket maximum**

- Applies to in-network pharmacy costs
- Retail and Home Delivery copays apply to the Pharmacy Out-of-Pocket

| Individual | $1,500 |
| Family     | $3,000 |
## Pharmacy Program Information

### Pharmacy Clinical Management and Prior Authorization
- Your plan is subject to refill-too-soon and other clinical edits as well as prior authorization requirements.
- Plan exclusion edits are always included.
- Additional clinical management - Enhanced package - a group of clinical medication management options that focus on various drug use management philosophies to help actively manage the pharmacy benefit include:
  - Benefits Exclusion - prior authorization, age edits and quantity over time edits.
  - Intensive Appropriateness of Use - duration of therapy edits, step therapy on new market entrants, and dose optimization edits.
  - Utilization and Unit Cost Management - prior authorization, quantity limits, maximum daily dose, and step therapy for limited class(es) of specific medications.

### Prescription Drug List:
- Your Cigna Standard Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.

### Specialty Pharmacy Management:
- Clinical Programs
  - Prior authorization is required on specialty medications but quantity limits may apply.
  - Theracare® Program
- Medication Access Option
  - Retail and/or Home Delivery
### Pharmacy Program Information

**Pharmacy Cost Management Program**

**Step Therapy** is a prior authorization program that may require you to try other medications available to treat the same condition before the "Step Therapy" medication is covered.

- All possible Step Therapy medications are identified on the Cigna prescription drug list with an "ST" suffix. To determine if a specific drug is subject to Step Therapy for your plan, please call Customer Service at the phone number listed on your ID card or visit the Prescription Drug Price Quote tool on myCigna.com.

#### High Blood Pressure (ACEI/ARB)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

#### Cholesterol Lowering (STATIN)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

#### Heartburn/Ulcer (PPI)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

#### Bladder Problems (OAB)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

#### Osteoporosis (Bone)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

#### Sleep Disorders (HYPNOTICS)
- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

#### Allergy (Nasal Steroids)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
### Pharmacy Program Information

- First Fill Pay and Educate included

#### Depression (SSRI/SNRI)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

#### Skin Conditions (TI)
- Generic First One Step - Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

#### Mental Health (ATYPICAL_PSYCHS)
- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

#### Non-Narcotic Pain relievers (NSAID)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

#### ADD/ADHD (ADHD)
- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

#### Asthma (ASTHMA)
- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

#### Narcotic Pain Relievers (NARCOTICS)
- Generic First One Step - Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

### Additional Information

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

<table>
<thead>
<tr>
<th>Comprehensive Oncology Program</th>
<th>Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care Management outreach</td>
<td></td>
</tr>
<tr>
<td>• Case Management</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Advisor - A</th>
<th>Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for healthy and at-risk individuals to help them stay healthy</td>
<td></td>
</tr>
<tr>
<td>• Health and Wellness Coaching</td>
<td></td>
</tr>
<tr>
<td>• Gaps in Care coaching for select conditions</td>
<td></td>
</tr>
<tr>
<td>• Preference Sensitive Care/Treatment Decision Support Coaching</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Multiple Surgical Reduction</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-Certification - Continued Stay Review - PHS+ Inpatient</th>
<th>required for all inpatient admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Network: Coordinated by your physician</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-Certification - Continued Stay Review - PHS+ Outpatient Prior Authorization</th>
<th>required for selected outpatient procedures and diagnostic testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Network: Coordinated by your physician</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-Existing Condition Limitation (PCL)</th>
<th>does not apply.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Your Health First - 200</th>
<th>Holistic health support for the following chronic health conditions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:</td>
<td>• Heart Disease</td>
</tr>
<tr>
<td>• Condition Management</td>
<td>• Coronary Artery Disease</td>
</tr>
<tr>
<td>• Medication adherence</td>
<td>• Angina</td>
</tr>
<tr>
<td>• Risk factor management</td>
<td>• Congestive Heart Failure</td>
</tr>
<tr>
<td>• Lifestyle issues</td>
<td>• Acute Myocardial Infarction</td>
</tr>
<tr>
<td>• Health &amp; Wellness issues</td>
<td>• Peripheral Arterial Disease</td>
</tr>
<tr>
<td>• Pre/post-admission</td>
<td>• Asthma</td>
</tr>
<tr>
<td>• Treatment decision support</td>
<td>• Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)</td>
</tr>
<tr>
<td>• Gaps in care</td>
<td>• Diabetes Type 1</td>
</tr>
<tr>
<td></td>
<td>• Diabetes Type 2</td>
</tr>
<tr>
<td></td>
<td>• Metabolic Syndrome/Weight Complications</td>
</tr>
<tr>
<td></td>
<td>• Osteoarthritis</td>
</tr>
<tr>
<td></td>
<td>• Low Back Pain</td>
</tr>
<tr>
<td></td>
<td>• Anxiety</td>
</tr>
<tr>
<td></td>
<td>• Bipolar Disorder</td>
</tr>
<tr>
<td></td>
<td>• Depression</td>
</tr>
</tbody>
</table>
### Definitions

**Coinsurance** - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.

**Copay** - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

**Deductible** - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

**Out-of-Pocket Maximum** - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.

**Prescription Drug List** - The list of prescription brand and generic drugs covered by your pharmacy plan.

**Transition of Care** - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

### Exclusions

**What's Not Covered (not all-inclusive):**

Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- 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.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
  - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
- The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy. Movement therapy. Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
Exclusions

- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances 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.
- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), 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.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, or mental retardation.
- Therapy or treatment intended primarily to improve or maintain general physical 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.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
Exclusions

- 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 nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, email, and Internet consultations, and telemedicine.
- Massage therapy.

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

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EHB State: FL
## Important Questions

### What is the overall deductible?

For in-network providers **$1,000** person / **$3,000** family

Does not apply to in-network preventive care & immunizations, in-network office visits, prescription drugs

Co-payments don't count toward the **deductible**.

**Why this Matters:**

You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.

### Are there other deductibles for specific services?

No.

**Why this Matters:**

You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.

### Is there an out-of-pocket limit on my expenses?

Yes. For in-network providers **$4,000** person / **$10,000** family

For in-network prescription drugs - **$1,500** person / **$3,000** family

The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

### What is not included in the out-of-pocket limit?

Premium, balance-billed charges, and health care this plan doesn't cover.

**Why this Matters:**

Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

### Is there an overall annual limit on what the plan pays?

No.

The chart starting on page 2 describes any limits on what the plan will pay for **specific** covered services, such as office visits.

### Does this plan use a network of providers?

Yes. For a list of participating providers, see [www.myCigna.com](http://www.myCigna.com) or call 1-800-Cigna24

**Why this Matters:**

If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

### Do I need a referral to see a specialist?

No. You don't need a referral to see a specialist.

You can see the **specialist** you choose without permission from this plan.

### Are there services this plan doesn't cover?

Yes.

Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-Cigna24 to request a copy.
- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if you use an</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 co-pay/visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$45 co-pay/visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$45 co-pay/visit for chiropractor</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge/visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$75 co-pay per type of scan/day</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your Cost if you use an</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-----------------------</td>
<td>-------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$0 co-pay/prescription (preventive) / $25 co-pay/prescription (retail), $25 co-pay/prescription (home delivery)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.myCigna.com">www.myCigna.com</a></td>
<td>Preferred brand drugs</td>
<td>$50 co-pay/prescription (retail), $100 co-pay/prescription (home delivery)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$70 co-pay/prescription (retail), $140 co-pay/prescription (home delivery)</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$150 co-pay/visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>In-network per visit co-pay is waived for non-surgical procedures</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room services</td>
<td>$150 co-pay/visit</td>
<td>$150 co-pay/visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$75 co-pay/visit</td>
<td>$75 co-pay/visit</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com.
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### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost if you use an In-Network Provider</th>
<th>Your Cost if you use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room) $150 co-pay/day</td>
<td>Not Covered</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees No charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services $45 co-pay/office visit and no charge other outpatient services Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services $150 co-pay/day</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services $45 co-pay/office visit and no charge other outpatient services</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services $150 co-pay/day</td>
<td>Not Covered</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care No charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services $150 co-pay/day</td>
<td>Not Covered</td>
<td>Co-pay maximum of $750 per calendar year.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care No charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services $45 co-pay/visit</td>
<td>Not Covered</td>
<td>Coverage is limited to 60 days in-network annual max.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services Not Covered</td>
<td>Not Covered</td>
<td>Coverage is limited to annual max of: 60 days for Rehabilitation and Spinal manipulation services; 36 days for Cardiac rehab services.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care No charge</td>
<td>Not Covered</td>
<td>Coverage is limited to 60 days annual max.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment No charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services No charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye Exam Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glasses Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dental check-up Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

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Excluded Services & Other Covered Services

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Dental care (Children)</td>
</tr>
<tr>
<td>• Eye care (Children)</td>
</tr>
<tr>
<td>• Habilitation services</td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Spinal manipulation services</td>
</tr>
</tbody>
</table>
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Florida Office of Insurance Regulation at 877-693-5236.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

----------------------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------------
# Coverage Examples

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

---

### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Note:

These numbers assume enrollment in individual-only coverage.

---

<table>
<thead>
<tr>
<th>Having a baby</th>
<th>Managing type 2 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $6,610</td>
<td><strong>Plan pays:</strong> $3,480</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $930</td>
<td><strong>Patient pays:</strong> $1,920</td>
</tr>
</tbody>
</table>

### Sample care costs:

<table>
<thead>
<tr>
<th>Having a baby</th>
<th>Managing type 2 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother) $2,700</td>
<td>Prescriptions $2,900</td>
</tr>
<tr>
<td>Routine Obstetric Care $2,100</td>
<td>Medical equipment and supplies $1,300</td>
</tr>
<tr>
<td>Hospital charges (baby) $900</td>
<td>Office visits &amp; procedures $700</td>
</tr>
<tr>
<td>Anesthesia $900</td>
<td>Education $300</td>
</tr>
<tr>
<td>Laboratory tests $500</td>
<td>Laboratory tests $100</td>
</tr>
<tr>
<td>Prescriptions $200</td>
<td>Vaccines, other preventive $100</td>
</tr>
<tr>
<td>Radiology $200</td>
<td><strong>Total</strong> $5,400</td>
</tr>
<tr>
<td>Vaccines, other preventive $40</td>
<td><strong>Patient pays:</strong></td>
</tr>
<tr>
<td><strong>Total</strong> $7,540</td>
<td>Deductible $0</td>
</tr>
<tr>
<td><strong>Patient pays:</strong></td>
<td>Co-pays $1,640</td>
</tr>
<tr>
<td>Deductible $300</td>
<td>Co-insurance $0</td>
</tr>
<tr>
<td>Co-pays $600</td>
<td>Limits or exclusions $280</td>
</tr>
<tr>
<td>Co-insurance $0</td>
<td><strong>Total</strong> $1,920</td>
</tr>
<tr>
<td>Limits or exclusions $30</td>
<td></td>
</tr>
</tbody>
</table>
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?
- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?
For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?
- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?
- **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?
- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?
- **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Plan ID:** 5201852  **BenefitVersion:** 7  
**Plan Name:** HMO 1 FDOA2020  
HP-POL/HP-APP 9/23/12
City of Hallandale Beach

ANNUAL COMPLIANCE RIDER

EFFECTIVE DATE: October 1, 2016

ACFLM16
3337286

This document printed in July, 2016 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

ANNUAL COMPLIANCE RIDER

No. ACFLM16

Policyholder: City of Hallandale Beach

Rider Eligibility: Each Employee

Policy No. or Nos. 3337286-HMO1

EFFECTIVE DATE: October 1, 2016

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

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

This Annual Compliance Rider replaces any other Annual Compliance Rider issued to you on a prior date.

The provisions set forth in this Annual Compliance Rider comply with legislative requirements of the State of Florida regarding group insurance plans covering insureds. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

READ THE FOLLOWING

NOTE: The provisions identified in this rider are specifically applicable ONLY for:

- Benefit plans which have been made available by your Employer to you and/or your Dependents;
- Benefit plans for which you and/or your Dependents are eligible;
- Benefit plans which you have elected for you and/or your Dependents;
- Benefit plans which are currently effective for you and/or your Dependents.

Anna Krishtul, Corporate Secretary

HC-RDR1 04-10 V1 AC
Important Notices

Important Information

Mental Health Parity and Addiction Equity Act

The Certificate is amended as stated below:

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

The Schedule and Mental Health and Substance Abuse Covered Expenses:

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

Mental Health and Substance Abuse Services

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

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

Inpatient Mental Health Services

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

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

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

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

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

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

Inpatient Substance Abuse Rehabilitation Services

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

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

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

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

Outpatient Substance Abuse Rehabilitation Services

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

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

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

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

**Mental Health and Substance Abuse Exclusions:**
The following exclusion is hereby deleted and no longer applies:

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

**Terms within the agreement:**
The term “mental retardation” within your Certificate is hereby changed to “intellectual disabilities”.

**Visit Limits:**
Any health care service billed with a Mental Health or Substance Abuse diagnosis, will not incur a visit limit, including but not limited to genetic counseling and nutritional evaluation/counseling.
Prior Authorization/Pre-Authorized
The following replaces any existing bullet regarding inpatient Hospital services in the Prior Authorization/Pre-Authorized section of your medical certificate for services that require Prior Authorization:

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

Medical Conversion Privilege
The following replaces the Medical Conversion Privilege page in the Medical Conversion section of your Certificate:

For You and Your Dependents
When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).
A Converted Policy will be issued by Cigna only to a person who:

- resides in a state that requires offering a conversion policy,
- is Entitled to Convert, and
- applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert
You are Entitled to Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased but only if:

- you are not eligible for other individual insurance coverage on a guaranteed issue basis.
- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.

- your insurance did not cease because the policy in its entirety canceled.

If you retire, you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert
The following Dependents are also Entitled to Convert:

- a child who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for other individual insurance coverage on a guaranteed issue basis, is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured
A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy
If you reside in a state that requires the offering of a conversion policy, the Converted Policy will be one of Cigna's current conversion policy offerings available in the state where you reside, as determined based upon Cigna's rules.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you
may convert. If you are not Entitled to Convert and your spouse and children are Entitled to Convert, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

**Exclusions, Expenses Not Covered and General Limitations**

The bullet regarding phase I, II or III clinical trials under the experimental, investigational or unproven services exclusion found in the **Exclusions, Expenses Not Covered and General Limitations** section of your medical certificate is revised as follows:

- 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.

**When You Have A Complaint Or An Appeal**

The following replaces the existing section of your medical certificate entitled **When You Have A Complaint Or An Appeal**:

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

**Start with Customer Service**

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call, or write to us at the following:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

** Appeals Procedure**

Cigna has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Cigna has a single level appeals procedure for Florida Adverse Determination appeals which are Medical Necessity appeals received in writing within 30 calendar days of the initial Medical Necessity denial. Cigna has a two step appeals procedure for the appeal of coverage decisions which are not Florida Adverse Determinations. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

**Level One Appeal**

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal.
for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level one appeal would be detrimental to your medical condition.

Cigna’s Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

**Level Two Appeal**

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

If the appeal involves a coverage decision based on issues of Medical Necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician Reviewer in the same or similar specialty as the care under consideration, as determined by Cigna’s Physician Reviewer. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was not involved in any previous decision related to your appeal, and not a subordinate of previous decision makers. Provide all relevant documentation with your second-level appeal request.

For required preservice and concurrent care coverage determinations, Cigna’s review will be completed within 15 calendar days. For postservice claims, Cigna’s review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the decision within five working days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna’s Physician Reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

**Independent Review Procedure**

If you are not fully satisfied with the decision of Cigna’s level two appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant’s rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna’s level two appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if a delay would be detrimental to your condition, as determined by Cigna’s Physician Reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from the facility, the review shall be completed within 72 hours.

**Florida Adverse Determination Medical Necessity Appeal**

To initiate an Adverse Determination appeal, you must submit a request in writing to Cigna within 30 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable to write, you may ask Cigna to assist so that you may register your written
appeal. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form. Your appeal will be reviewed and the decision made by individuals not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by an Internal Panel of health care professionals. For appeals involving Medical Necessity or clinical appropriateness, the Internal Panel will include at least one Physician in the same or similar specialty as the care under consideration, as determined by the Cigna Physician Reviewer.

For Adverse Determination Medical Necessity Appeals, we will acknowledge in writing that we have received your request and schedule a panel review. For preservice and concurrent care coverage determinations, the panel review will be completed within 30 calendar days and for postservice claims, the panel review will be completed within 60 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Internal Panel to complete the review.

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

You will be notified in writing of the Internal Panel's decision within five working days after the panel considers your request. You may request that the appeal process be expedited if: (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited Medical Necessity appeal would be detrimental to your medical condition.

The Cigna Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

Appeal to the State of Florida
You have the right to contact the state regulators for assistance at any time. The state regulators may be contacted at the following addresses and telephone numbers:

- The Agency for Health Care Administration
  Fort Knox Building One, Room 339
  2727 Mahan Drive
  Tallahassee, FL 32308
  1-888-419-3456

- Florida Office of Insurance Regulation
  200 East Gaines St.
  Tallahassee, FL 32399-0300
  1-800-342-2762

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

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

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

**Legal Action**

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action. However, no action will be brought at all unless brought within five years after proof of claim is required under the Plan. However, no action will be brought at all unless brought within five years after a claim is submitted for In-Network services.

**Definitions**

**Dependent**

The paragraph that reads “Anyone who is eligible as an employee will not be considered as a Dependent” shown under the “Dependent” definition in the Definitions section in your medical certificate is replaced with the following:

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

**The Schedule**

If you are enrolled in a Comprehensive medical plan or an In-Network only medical plan and subject to Out-of-Pocket maximums, the following provision is added to The Schedule shown in your medical certificate:

**Out-of-Pocket Expenses**

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

In addition, any existing “Out-of-Pocket Expenses” paragraph in The Schedule of your Comprehensive medical plan or In-Network only medical plan certificate is hereby removed.

The following paragraph, if included in your Pharmacy Schedule, is hereby revised to read as follows:

**Out-of-Pocket Expenses**

Out-of-Pocket Expenses are Covered Expenses incurred at a Pharmacy for Prescription Drugs and Related Supplies for which no payment is provided because of the Coinsurance factor and any Copayments or Deductibles. When the Out-of-Pocket Maximum shown in The Schedule is reached, benefits are payable at 100%.

The following paragraph, found in your Pharmacy Schedule, is hereby revised to read as follows:

Certain medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no copayment or deductible, when purchased from a Participating Pharmacy. A written prescription is required.
Exclusions
The bullet regarding prescription smoking cessation products in the “Pharmacy Exclusions” section of your medical certificate is amended to indicate the following:

• prescription smoking cessation products, unless state or federal law requires coverage of such products;

Federal Requirements
The following Federal Requirements replace any such provisions shown in your Certificate.

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)
Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

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

A. Coverage Elections
Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

• the date you meet the Special Enrollment criteria described above; or
• the date you meet the criteria shown in the following Sections B through H.

B. Change of Status
A change in status is defined as:

• change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
• change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
• change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence,
including under the Family and Medical Leave Act (FMLA), or change in worksite;

- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer’s network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

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

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

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

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

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

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

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

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

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

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

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

Any Pre-existing Condition Limitation under this plan will no longer be imposed.

HC-FED32 04-11 AC1

Obtaining a Certificate of Creditable Coverage Under This Plan

The section entitled “Obtaining a Certificate of Creditable Coverage Under This Plan” shown under the Federal Requirements provision of your medical certificate is hereby removed.

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your Dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call the toll-free customer service number on the back of your ID card.

HC-FED54 12-13 AC1

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

The following paragraphs regarding the “Trade Act of 2002” are hereby rendered NULL and VOID:

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

HC-FED54 10-10 AC1

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

Who is Entitled to COBRA Continuation?

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

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals’ coverage will terminate when your COBRA continuation coverage terminates. The sections titled “Secondary Qualifying Events” and “Medicare Extension For Your Dependents” are not applicable to these individuals.
In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under “Termination of COBRA Continuation” above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

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

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

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

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: October 1, 2016

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This document printed in July, 2016 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

Policyholder: City of Hallandale Beach
Rider Eligibility: Each Employee as noted within this certificate rider
Policy No. or Nos.: 3337286
Effective Date: October 1, 2016

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

IMPORTANT INFORMATION

For Residents of States other than the State of Florida:

State-specific riders contain provisions that may add to or change your certificate provisions.

The provisions identified in your state-specific rider, attached, are ONLY applicable to Employees residing in that state. The state for which the rider is applicable is identified at the beginning of each state specific rider in the "Rider Eligibility" section.

Additionally, the provisions identified in each state-specific rider only apply to:
(a) Benefit plans made available to you and/or your Dependents by your Employer;
(b) Benefit plans for which you and/or your Dependents are eligible;
(c) Benefit plans which you have elected for you and/or your Dependents;
(d) Benefit plans which are currently effective for you and/or your Dependents.

Please refer to the Table of Contents for the state-specific rider that is applicable for your residence state.

Anna Krishtul, Corporate Secretary

HC-ETRDR
CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Georgia Residents

Rider Eligibility: Each Employee who is located in Georgia

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Georgia group insurance plans covering insureds located in Georgia. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Covered Expenses

- charges made for colorectal cancer screening, examinations and laboratory tests according to the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology, if deemed appropriate by the Physician in consultation with the insured.

When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Customer Service

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

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Cigna has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing, within 365 days of receipt of a denial notice, to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.
If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

Cigna's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

**Level Two Appeal**

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Requests for a level-two appeal regarding the Medical Necessity or clinical appropriateness of your issue will be conducted by a Committee, which consists of at least three people not previously involved in the prior decision. The Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by Cigna's Physician Reviewer. You may present your situation to the Committee in person or by conference call.

For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level-two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician Reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

**Independent Review Procedure**

If you are not fully satisfied with the decision of Cigna’s level two appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if a delay would be detrimental to your condition, as determined by Cigna’s Physician Reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have no yet been discharged from the facility, the review shall be completed within 72 hours.

**Notice of Benefit Determination on Appeal**

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.
You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

**Relevant Information**

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

**Legal Action**

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna in federal court until you have completed the level one and level two Appeal processes. If your Appeal is expedited, there is no need to complete the level two process prior to bringing legal action. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services.

**Appeal to the State of Georgia**

You have the right to contact the Department of Insurance or the Department of Human Resources for assistance at any time. The Department of Insurance or the Department of Human Resources may be contacted at the following respective addresses and telephone numbers:

- Georgia Department of Insurance
  2 Martin Luther King, Jr. Drive
  Floyd Memorial Bldg, 704 West Tower
  Atlanta, GA 30334
  404-656-2056

- Georgia Dept. of Human Resources
  Two Peachtree Street, NW
  Suite 33.250
  Atlanta, GA 30303-3167
  404-657-5550

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

**CERTIFICATE RIDER – Kentucky Residents**

Rider Eligibility: Each Employee who is located in Kentucky

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Kentucky group insurance plans covering insureds located in Kentucky. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.
The Schedule

For charges made for Medically Necessary treatment of Mental Health and Substance Abuse Services, including any related prescription drug charges, Covered Expenses will be payable the same as for other illnesses, including any deductibles, Lifetime or annual maximums, day or visit or dollar limits, episodes of care limits, copayments, coinsurance levels, accumulation to any out-of-pocket amount, any increase to 100% once the out-of-pocket amount has been reached, and any other cost-sharing arrangements. Any Mental Health or Substance Abuse deductibles, maximums, limits, copayments, coinsurance levels, out-of-pocket provisions, and cost-sharing arrangements shown in The Schedule that are not the same as for other illnesses will not apply.

Covered Expenses

- charges for cochlear implants for persons age 2 and over with the diagnosis of profound sensorineural deafness or postlingual deafness in adults. Cochlear implants for children under age 2 will be covered when, upon review, they are determined to be Medically Necessary.

- charges for the diagnosis and treatment of Autism Spectrum Disorders:
  - treatment for Autism Spectrum Disorders includes medical care, habilitative or rehabilitative care, pharmacy if covered by the plan, psychiatric care, psychological care, therapeutic care, and applied behavior analysis prescribed or ordered by a licensed health professional.
  - coverage is not subject to visit limits. Coverage is not subject to copayments, deductibles, or coinsurance that is less favorable than those applied to other covered services.
  - Cigna may request utilization review of the treatment once every 12 months, unless Cigna and the covered person’s licensed Physician, psychiatrist, or psychologist agree that a more frequent review is necessary.

- charges for a telehealth consultation provided the treating Physician or other provider facilitating the use of telehealth ensures that: informed consent of the patient or another person with authority to make the health care treatment decision for the patient, is obtained before covered services are provided through telehealth; and that the confidentiality of the patient's medical information and quality of care protocols are maintained. Telehealth means the use of interactive, audio, video or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data and medical education.

- charges for the necessary care and treatment of medically diagnosed inherited metabolic diseases. Coverage must include amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases provided that the amino acid products are prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic diseases, and are administered under the direction of a Physician.

- charges for or in connection with hospitalization, ambulatory surgical facility charges and general anesthesia for dental procedures provided the person being treated is: under nine years of age; or has serious mental, physical or behavioral problems and the Dentist or admitting Physician certifies that hospitalization or anesthesia is required to safely perform the procedures effectively.

- charges for hearing aids and all related services for persons under 18 years of age when prescribed by licensed audiologists and dispensed by an audiologist or hearing instrument specialist. Coverage will be limited to the full cost of one hearing impaired ear up to $1,400 every 36 months. Related services are services necessary to assess, select and appropriately adjust or fit the hearing aid to ensure optimal performance. A hearing aid is any wearable, nondisposable instrument or device designed to aid or compensate for impaired hearing and any parts, attachments or accessories, including earmolds, but excluding batteries and cords.

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- medical and Hospital care and costs for the infant child of a Dependent beyond the first 31 days of life, unless this infant child is otherwise eligible under this plan.

myCigna.com
Termination of Insurance
Special Continuation of Medical Insurance
For Employees and Dependents
If your Medical Insurance would cease and if you have been insured for at least three consecutive months under this policy or a policy it replaces, upon payment of the required premium by you to your Employer, your Medical Insurance will be continued until the earliest of:
- 18 months from the date Medical Insurance would otherwise cease;
- the last day for which you have paid the required premium;
- the date you become eligible for insurance under another group policy for medical benefits or under Medicare;
- for a Dependent, the date that Dependent no longer qualifies as a Dependent;
- the date the policy cancels.
Your Employer will notify you in writing of your right to elect such continuation by sending you an election of continuation of coverage form, samples of which have been provided by the Insurance Company.
Within 31 days after the date notice was sent to you, you may elect such continuation in writing by returning the election of continuation of coverage form and paying the required premium.

When You Have A Complaint Or An Appeal
For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.
We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Customer Service
We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form.
We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.
If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure
Cigna has a one step appeal procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing, within 365 days of receipt of a denial notice, to the following address:
Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422
You may also initiate an appeal when Cigna has not made and provided written notice of an initial utilization review determination within allowable time frames. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Internal Appeals
You, an authorized person, or a provider, acting on your behalf, may request an internal appeal if you are dissatisfied with the initial Medical Necessity or clinical appropriateness decision or a coverage denial decision, or we have failed to make and communicate in writing an initial Medical Necessity or clinical appropriateness determination within allowable time frames.
Under federal law, you are allowed up to four (4) months after the date of receipt of a notice of adverse determination or final adverse determination to file a request for external review.

Coverage Denial Appeals
Your appeal of a Coverage Denial determination for which a service, treatment, prescription drug, or device is specifically limited, excluded or denied under the plan will be reviewed and the decision made by someone not involved in the initial decision and not a subordinate of previous decision makers. Provide all relevant documentation with your appeal request.
For required preservice and concurrent care coverage determinations, Cigna’s review will be completed within 30 calendar days of the receipt of your appeal request. For postservice claims, Cigna’s review will be completed within 30 calendar days. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to you as soon as possible and sufficiently in
advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the decision within five working days after the decision is made, and within the review time frames above. Notification of the appeal review decision will be provided to you and any designated representative and provider(s) acting on your behalf.

**Medical Necessity Appeals**

Your appeal of Cigna's adverse determination, decision to deny, reduce or terminate a medical service based on a determination that it is not Medically Necessary or is experimental or investigational, will be considered by a Physician, or upon your request, by a reviewer, in the same or similar specialty as the care under consideration, who was not involved in the initial decision as determined by Cigna's Physician Reviewer.

For required preservice and concurrent care coverage determinations, Cigna's review will be completed within 30 calendar days of the receipt of your appeal request. For postservice claims, Cigna’s review will be completed within 30 calendar days. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with your appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the decision to uphold or reverse the decision of the Physician Reviewer within five working days after the decision is made, and within the review time frames above. Notification of the appeal review decision will be provided to you and any designated representative and provider(s) acting on your behalf.

**Expedited Internal Appeals**

An expedited appeal will be provided when you are hospitalized or as requested when the treating provider is of the opinion that review under a standard time frame could, in the absence of immediate medical attention, result in any of the effects listed in the following paragraph.

You may request that the appeal process be expedited for an appeal of a Medical Necessity Adverse Determination or an appeal of a Coverage Denial if: (a) the time frames under this process would seriously jeopardize your life or health, or with respect to a pregnant woman, the life or health of the unborn child; or the ability to regain maximum function; or result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part; or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

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

When an appeal is expedited, we will respond orally with a decision within 72 hours of receipt of the appeal request, followed up in writing within three working days.

**Reconsideration of an Internal Review Medical Necessity or Clinical Appropriateness Appeal Decision**

You may present new clinical information regarding an adverse internal review appeal determination decision prior to the initiation of the external review process conducted by an Independent Review Entity in the process described in the following paragraph entitled, "External Review by an Independent Review Entity." If you do, Cigna will provide written notice of a reconsideration decision within five working days of receiving additional information related to the request for reconsideration. If a reconsideration is requested, the four months time frame for requesting an external review by an Independent Review Entity shall not begin until Cigna provides the reconsideration decision. If we do not provide a written reconsideration decision within the allowable time frame, then you may request an external review by an Independent Review Entity. Notification of the reconsideration of the appeal review decision will be provided to you and any designated representative or provider(s) acting on your behalf.

**External Review by an Independent Review Entity**

If you are not fully satisfied with the decision of Cigna's internal appeal decision or reconsideration decision regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Entity (IRE).

Your appeal of Cigna's adverse determination, decision to deny, reduce or terminate a medical service based on a determination that it is not Medically Necessary or is experimental or investigational, will be considered by a Physician or upon your request, by a reviewer, in the same or similar specialty as the care under consideration, who was not involved in the initial decision as determined by Cigna's Physician Reviewer. The Independent Review Entities that Kentucky Department of Insurance assigns in rotation to requests for external independent review are: certified by the Kentucky Department of Insurance, and composed of persons who are not employed by Cigna HealthCare or any of its subsidiaries.
affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights of any other benefits under the plan.

An IRE will provide an expedited review of an external appeal when requested, and any of the following apply: the treating Physician believes that independent review under a standard time frame would seriously jeopardize your life or health, or with respect to a pregnant woman, the life or health of the unborn child; or the ability to regain maximum function; or result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part; or would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

Cigna will pay the cost of the review of an Independent Review Entity, however, there is a $25 filing fee for you to initiate this independent review process, and you will be billed for this directly by the IRE. The IRE will waive the fee if financial hardship can be demonstrated and will refund the fee if their review results in a decision favorable for you. Cigna will abide by the decision of the IRE, and will provide notice to the Kentucky Department of Insurance of its implementation of the decision within 30 days of the IRE’s decision in your favor. Cigna will provide coverage of the treatment, service, drug or device as required by the binding decision of the IRE, if you are currently enrolled for coverage by Cigna or you have disenrolled. If you have disenrolled, Cigna will only provide the treatment, service, drug, or device for a period of 30 days.

Call the toll-free number on your Benefit Identification card or contact the appeals representative indicated on your appeal decision notification letter for information about how to request an external review appeal by an IRE.

In order to request a referral to an IRE the following conditions apply: you must submit your request in writing to Cigna, within 60 days of the date of this letter (except that requests for expedited appeals may be requested verbally, followed up by an abbreviated written request). However, when a reconsideration of this decision is requested due to the submission of new clinical information, the 60-day time frame limit for requesting an external review by an IRE will not begin until Cigna has provided a reconsideration decision; you provide a signed copy of the medical release form which provides permission for the IRE to obtain all of the necessary medical records in order to complete its review; you were insured at time of service, or when you or your provider requested the service you have exhausted the Cigna internal review process and received an adverse decision regarding your request involving a Medical Necessity issue; or Cigna has not completed its review of your internal review appeal within the required 30 days; or the Kentucky Department of Insurance has provided notice that Cigna’s Coverage Denial determination is not valid because the requested service or coverage is available under the plan. If you believe that you are entitled to an IRE review and Cigna has denied your request for an IRE review, you may file a complaint with the Kentucky Department of Insurance, which shall issue a decision within five days of the receipt of your complaint. If the Department agrees that you are entitled to an IRE review, it shall require Cigna to provide one, as noted above.

If both Cigna and you agree to waive the internal appeal requirement, you may also request that your eligible issue be referred directly to an IRE without initiating or exhausting the internal appeals process.

Cigna will not provide an external review by an IRE if the request for review of the adverse determination has previously gone through the external review process and the IRE found in favor of Cigna and no new clinical information has been submitted since the IRE found in favor of Cigna.

Cigna will forward your request and the file to the IRE, after the Department of Insurance assigns an IRE to your review request.

If you believe that you are entitled to an IRE review and Cigna has denied your request for an IRE review, you may file a complaint with the Kentucky Department of Insurance, which shall issue a decision within five days of the receipt of your complaint. If the Department agrees that you are entitled to an IRE review, it shall require Cigna to provide one, as noted above.

The IRE will render an opinion within 21 calendar days, unless you and Cigna agree to an extension of up to 14 calendar days more. When requested, and when your provider believes that review under a standard time frame would be detrimental to your medical condition, Cigna shall forward your request for an IRE review to the IRE within 24 hours of receiving it, and the IRE will make a decision within 24 hours of receipt of all information required from Cigna. If you agree to a 24-hour extension for the expedited review, then the IRE will provide an expedited decision of the review request within 48 hours of receiving it from Cigna.

The external review process shall be confidential.
External Review of a Coverage Denial by the Kentucky Department of Insurance

You have the right to ask the Kentucky Department of Insurance to review a Coverage Denial determination that has been made following an internal appeal. A Coverage Denial means a determination that a service, treatment, prescription drug or device is specifically limited or excluded under the Plan. You, or an authorized person or provider on your behalf, may submit a written request for review of a Coverage Denial to the Kentucky Department of Insurance at the following address:

Kentucky Department of Insurance
Attn: Coverage Denial Coordinator
P.O. Box 517
Frankfort, KY 40602-0517

Include a copy of the initial Cigna denial notice and the appeal notice with your written request for review of a Coverage Denial. Upon Cigna's receipt of the Kentucky Department of Insurance's (DOI) determination decision of your Coverage Denial review request, Cigna will: provide the disputed coverage if the DOI has concluded that the treatment, service, drug or device is not specifically limited or excluded by the plan or offer you the opportunity to seek an external review by an Independent Review Entity; or not provide the disputed coverage if the DOI has concluded that the treatment, service, drug or device is not specifically limited or excluded by the plan. When Cigna provides the coverage because the DOI has determined the treatment, service, drug or device is not specifically limited or excluded by the plan, it will provide coverage if you are currently enrolled for coverage by Cigna or you have disenrolled. If you have disenrolled, Cigna will only provide coverage for the treatment, service, drug, or device for a period of 30 days.

Appeal to the State of Kentucky

You have the right to contact the Kentucky Department of Insurance for assistance at any time. The Kentucky Department of Insurance may be contacted at the following address and telephone number:

Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517
1-800-595-6053
Hearing Impaired: 1-800-462-2081

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal; an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; date of the review decision; name and title of the person making the review decision and for Medical Necessity determinations, the name, state of licensure, medical license number and the title of the person making the determination and, as applicable to managed care plans, the signature of a Kentucky-licensed Medical Director; a description of alternative benefits, supplies or services covered by the plan; instructions for requesting an external review by either an IRE or the Kentucky Department of Insurance, as applicable, including applicable time frames and instructions to complete any required forms and whether the request for review of the appeal decision must be in writing; for Medical Necessity appeal determinations, a release of medical records form for provision to the IRE; the name and phone number of a contact person who can provide information about a Coverage Denial determination or about external review by an IRE, as applicable; and for Coverage Denial appeal notices, instructions to include a copy of the initial Coverage Denial notice and the Coverage Denial notice with the written request to the Department of Insurance to conduct a review of a Coverage Denial appeal determination; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process.

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

Relevant Information

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Internal Review Appeal process. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services.

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

CERTIFICATE RIDER – Vermont Residents

Rider Eligibility: Each Employee who is located in Vermont

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Vermont group insurance plans covering insureds located in Vermont. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Special Plan Provisions

Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide, or your Cigna HealthCare Directory, for a list of Participating Providers in your area. You can also call the toll-free number shown on the back of your ID card if you:

- have a question about a provider; or
- need help finding a Participating Provider; or
- desire an updated provider list.

Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs. Cigna does not offer any financial inducements to Participating Providers and facilities contracted in Vermont for the reduction or limitation of health care services.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card, or by calling us at our general Customer Service/Member Services number: 1-800-351-8513.

Important Notices

Vermont Mandatory Civil Unions Endorsement for Health Insurance

Purpose:

Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons. This endorsement is part of and amends this policy, contract or certificate to comply with Vermont law.

Definitions, Terms, Conditions and Provisions

The definitions, terms, conditions and any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as “marriage,” “spouse,” “husband,” “wife,” “dependent,” “next of kin,” “relative,”...
“beneficiary,” “survivor,” “immediate family” and any other such terms include the relationship created by a civil union established according to Vermont law.

Terms that mean or refer to the inception or dissolution of a marriage, such as “date of marriage,” “divorce decree,” “termination of marriage” and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

Terms that mean or refer to family relationships arising from a marriage, such as “family,” “immediate family,” “dependent,” “children,” “next of kin,” “relative,” “beneficiary,” “survivor” and any other such terms include family relationships created by a civil union established according to Vermont law.

“Dependent” means a spouse, party to a civil union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent upon the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

“Child” or “covered child” means a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent upon the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

Caution: Federal Rights May or May Not Be Available

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Retirement Income Security Act of 1974 known as "ERISA," controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

Our Commitment to Quality

One of our goals is to work with network doctors to give you access to quality care and programs. The Cigna HealthCare Quality Management Program is based on industry standards and objective measures. These measures help us evaluate the quality of care and services you receive. The Quality Management Program helps us focus our improvement efforts where needed and allows for input from you, the customer, as well as network doctors. Improvement efforts are identified through regular analysis and the findings are reported to quality committees. Customers and network doctors serve on local health plan quality committees. The committees help us target areas in need of improvement and monitor change. Items included are:

- credentialing process for qualified doctors;
- ongoing assessment of clinical activities and services provided for you;
- Utilization Management activities and programs that serve you;
- program dedicated to communicating customer rights and responsibilities.

Your Role

Cigna HealthCare values your input and suggestions to improve care to our customers. Your participation in plan surveys gives us feedback on plan performance and policy developments.

You have the opportunity to provide input on our policies, serve on our health plan quality committee, or volunteer to participate in focus groups and surveys. Should you wish to provide feedback or receive more
information about the Cigna HealthCare Quality Management Program, the annual program evaluation, chronic care or preventive health measures, or our progress in meeting goals, please call 800-591-9407 to leave a message to receive a return call.

Specialist Physician Serving as Primary Care Physician for a Life-Threatening, Degenerative or Disabling Condition

In Vermont, a member may, upon Cigna approval, use a Specialist as their PCP for a life-threatening, degenerative or disabling condition. The request must include a signed statement from the member requesting the Specialist to serve as the member’s PCP and certification from the Specialist of the medical need to serve as the member’s PCP.

Upon receipt of this documentation:

- A Cigna Medical Director validates the Medical Necessity of the request.
- A decision is made within 10 business days or less from receipt of the request.
- If approved, Cigna will reach out for a signed statement from the Specialist accepting responsibility to serve as the member’s PCP, coordinate member care needs and accept the PCP contracted reimbursement rate for primary care services.
- If the Cigna Medical Director denies the request for a Specialist to serve as the member’s PCP, the denial notification includes the reason(s) for denial, appeal rights and confirmation that the determination was made by a Cigna Medical Director.
- The member will be notified in writing within 21 to 30 business days of the decision.

Mailing Address:
Cigna HealthCare
4100 International Pkwy
Suite 1010
Carrollton, TX 75007

Information Available to You Upon Your Request

Upon your request, by telephone or in writing to our Customer Service/Member Services office, we will provide you the information you need, if:

- you have a question about your coverage, your benefits, a provider, a claim, the services you received, a hospital stay, outpatient care; or
- you received a bill in error; or
- you have a complaint.

The following information is also available to you, if you call or write to Cigna. Or, you can log on to www.mycigna.com, and go to these pages: Provider Directory, Disclaimer, My Plans, and My Health.

- a list of providers and facilities;
- your coverage under this certificate, including a description of deductible, copayment and coinsurance amounts for which you are responsible;
- your plan’s drug Formulary, if any;
- a description of the prior approval or utilization review process;
- the clinical review criteria used in making service denials;
- a description of financial benefits offered to any provider or facility for the reduction or limitation of health care services, if any;
- a description of the process for choosing and credentialing providers, including those handling utilization review;
- a description of the grievance procedures: all information related to the subject of grievance begun by you;
- a description of how to select, change or receive referrals to providers;
- access to your individual medical records, for which you will not be charged more than the cost to copy them;
- a summary of the quality assessment and improvement programs; and
- any other information that the plan makes available to you upon request.

To obtain a complete copy of your group insurance certificate form online, please log on to

myCigna.com
www.mycigna.com, and follow the instructions for using the “Cignaaccess” employer portal to request the certificate through your employer.

Translation Information
If English is not your primary language, we will provide you with information about your interactions with Cigna under the policy and this certificate, in your primary language. To request this information, call or write us at the toll-free number or address shown on the back of your ID card. We have bilingual representatives in Spanish-speaking areas. We also offer the Language Line service that can translate almost any other language.

Access to Your Physician
Cigna studies the availability of, and access to, our Participating Providers each year.

Wait Times
You should expect to get appointments with Participating Providers according to these standards:

- Emergency care appointments: immediately.
- Urgent care appointments: within 24 hours.
- Routine Physician appointments: within 2 weeks.
- Routine lab, X-ray and general optometry: within 30 days.
- Preventive care: within 90 days.

Travel Times
- You should not have to travel longer than 30 minutes, from home or work, for personal Physician services and outpatient mental health/substance abuse treatment (if part of your healthcare plan).
- You should not have to travel longer than 60 minutes, from home or work, for prescription drugs, lab, X-ray and MRI services, eye exams, inpatient mental health treatment, and inpatient medical rehabilitation services.
- You should not have to travel longer than 90 minutes, from home or work, for kidney transplants, major trauma treatment, and open-heart surgery.

Description of Service Area
The network of Participating Providers and Participating Pharmacies established by Cigna is not limited to a defined geographical area near your home or work. Cigna maintains a national network of Participating Providers and Participating Pharmacies, to which you have access.

The Schedule
Any deductible or coinsurance applicable to annual routine or diagnostic mammograms does not apply.

Prior Authorization/Pre-Authorized
Prior Authorization is not required for Emergency Services.

Covered Expenses
- charges made for or in connection with mammograms for breast cancer screenings, not to exceed an annual mammogram for women age 40 or over, or mammograms for women less than age 40 upon recommendation of a health care provider.

Cancer Clinical Trials
Routine patient care services directly associated with a patient’s participation in a phase I, II, III or IV approved cancer clinical trial.

An “approved cancer clinical trial” is an organized, systematic, scientific study of therapies, tests, or other clinical interventions for purposes of treatment, palliation, or prevention of cancer in human beings.

The approved trial must:

- seek to answer a credible and specific medical or scientific question for the purpose of advancing cancer care;
- enroll only those patients for whom there is no clearly superior, noninvestigational treatment alternative;
- have available clinical or preclinical data that provides a reasonable expectation that the treatment obtained in the approved trial will be at least as effective as the noninvestigational alternative;
be conducted under the auspices of one of the following Vermont cancer care providers: Vermont Cancer Center at Fletcher Allen Health Care, the Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center, or approved clinical trials being administered by a Vermont hospital and its affiliated, qualified Vermont cancer care providers;

be conducted by a facility and personnel capable of conducting such a trial by virtue of experience, training and volume of patients treated to maintain such expertise;

be conducted under the auspices of a peer-reviewed protocol that has been approved by one of the following entities: one of the National Institutes of Health (NIH); an NIH-affiliated cooperative group that is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer-review program operating within the group; the FDA in the form of an investigational new drug application or exemption; or the federal department of Veterans Affairs or Defense.

“Routine patient care services” are any Covered Expenses under this plan, including any Medically Necessary health care service that is incurred as a result of the treatment being provided to the patient for the purposes of the approved cancer clinical trial. Routine patient care services do not include the following:

- the cost of investigational new drugs that have not been approved for market for any indication by the FDA, or the costs of any drug being studied under an FDA-approved investigational new drug exemption for the purpose of expanding the drug’s labeled indications.
- the costs of nonhealth care services that may be required as a result of the treatment being provided for the purposes of the approved cancer clinical trial.
- the costs of the services that are clearly inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis and performed specifically to meet the requirements of the approved cancer clinical trial.
- the costs of any tests or services performed specifically to meet the needs of the approved cancer clinical trial protocol.
- the costs of running the approved cancer clinical trial and collecting and analyzing data.

- the costs associated with managing the research associated with the approved clinical trial.
- the costs for noninvestigational treatments or services that would not otherwise be covered under the patient’s health benefit plan.
- any product or service paid for by the trial sponsor.

**Prescription Drug Benefits**

**For You and Your Dependents**

Cigna manages Prescription Drug Benefits. Procedures to do this may include Prescription Drug Lists, dose restrictions, prior authorization requirements, Step Therapy and drug substitution requirements. Pharmaceutical benefit management, with respect to particular drugs, may change frequently.

Please see our website at www.Cigna.com for the most current listing of Prescription Drug List drugs, or call the Customer Service/Member Services number on the back of your ID card. You can also get up-to-date Prescription Drug information by calling us at 1-800-835-3784.

**Covered Expenses**

When a change is made in Cigna’s pharmaceutical benefit management that applies a new or revised dose restriction that causes a prescription for a particular drug not to be covered for the number of doses prescribed, or applies a new or revised substitution, Step Therapy, prior authorization or any other requirement that causes a particular drug not to be covered until the requirements of that benefit management plan have been met, Cigna shall ensure:

- the change is published in the primary source of pharmaceutical benefit management information for you, your Dependents and providers as long in advance as possible but no less than 90 days prior to the effective date of the change;
- each covered person who is known to have an active prescription for the drug is individually notified in writing at least 90 days prior to the effective date of the change; and
- that if you or your Dependent request a fill or refill or a prescription written prior to publication of the change or receipt of the notice described above, the
prescription remains valid; and if it is not possible to timely obtain a prescription consistent with the change requirement, coverage will be provided for an interim supply of the drug and, if relevant, any additional supply that is Medically Necessary to discontinue the drug for up to 90 days, or until the prescribing Physician can order a new prescription or, if necessary, until the grievance and independent review process can be initiated and completed. Cigna shall not be required to cover an interim supply if:

- the covered person’s prescribing Physician explicitly consents to the change; or
- the drug has been determined to be unsafe for the treatment of the individual’s disease or medical condition, or has been discontinued from coverage for safety reasons, or cannot be supplied by, or has been withdrawn from the market by, the drug’s manufacturer.

Limitations

If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician should:

- call Cigna Pharmacy Services at (800) 244-6224; or
- complete and fax the appropriate prior authorization form to Cigna Pharmacy Services at (800) 390-9745 to provide information on the medication requested (name, strength and dosing schedule), the diagnosis related to use, the duration of therapy, the Prescription Drug List alternatives tried, and any additional pertinent information (clinical reasons for the drug, relevant lab values, etc.). Your Physician should make this request before writing the prescription.

For information on Prescription Drugs and Related Supplies that require prior authorization, log on to www.mycigna.com and use the “Drug List” search tab, or see the “For Health” page. Or, call Customer Service/Member Services at the toll-free number on the back of your ID card.

If your Physician describes the request as relating to treatment needed on an urgent basis, your Physician will be notified of Cigna’s decision within 24 hours after the request. If the Physician’s request is for a non-urgent treatment situation, Cigna will notify the Physician of its decision within 15 days after the request.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered. You may also request an expedited review of your appeal, as described in the “Preservice Medical Necessity Determinations” provision of this certificate.

As long as the drug continues to be prescribed for you or your Dependent and is considered safe for the treatment of the person’s condition, a person who has previously been prescribed an otherwise covered drug that is the subject of prior authorization, other review and/or denial shall be entitled to coverage for a supply of the drug sufficient to continue treatment through the following time periods, as well as any additional supply that is Medically Necessary to safely discontinue the drug if the denial is ultimately upheld:

- until Cigna has completed prior authorization or other review process;
- if applicable, until all required internal expedited grievances have been exhausted; and
- until the independent external review decision is issued, if expedited independent external review is requested within 24 hours of the receipt of the final grievance decision and notice of appeal rights by you or your Dependent, and expedited independent external review is conducted in accordance with the time frames specified by law.

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

A request for an exception to a pharmaceutical benefit management requirement or decision, including a requirement or decision relating to Step Therapy and Generic Drug issues, may be made in accordance with the “Prescription Drug Benefit Management Disclosure” provision of the When You Have a Complaint or an Appeal section of this certificate.
Exclusions, Expenses Not Covered and General Limitations

General Limitations
It is your responsibility to pay all charges for expenses incurred by you or any of your Dependents for:

- services and supplies that do not satisfy the certificate’s definitions of Covered Services; and
- services and supplies that are described as not covered in the Exclusions section of this certificate.

Medical Benefits Extension Upon Policy Cancellation
If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury or Sickness, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group policy;
- the date you are no longer Totally Disabled;
- 12 months from the date your Medical Benefits cease; or
- 12 months from the date the policy is canceled.

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

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

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

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

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when you or your Dependent’s Medical Benefits cease.

When You Have A Complaint Or An Appeal (Grievance)
For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Customer Service
We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you are welcome to call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

You must pay for services given by a Participating Provider or non-Participating Provider if your claim is denied.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Prescription Drug Benefit Management Disclosure
Cigna will allow an exception to a benefit management requirement described in this certificate that applies to coverage for Prescription Drugs and Related Supplies, and will provide coverage on the same basis as Cigna
would have for the benefit management requirement, if your Physician certifies, based on relevant clinical information about you and sound medical or scientific evidence or the known characteristics of the drug, that the benefit management requirement:

- has been ineffective, or is reasonably expected to be ineffective or significantly less effective in treating your condition, such that an exception is Medically Necessary; or
- has caused you, or is reasonably expected to cause you, adverse or harmful reactions.

To request an exception, your Physician should contact:

Cigna Pharmacy Management
Attn: Pharmacy Services Center
P.O. Box 29030
Phoenix, AZ 85038-9030
Tel. (800) 244-6224

Cigna will accept the Physician’s advance certification telephonically, when the Physician designates the situation to be an emergency. Cigna has the right to require the certification to be later confirmed in writing.

A denial of a request for an exception to a benefit management requirement is a determination subject to independent external review under Vermont law. In this situation, the terms of the “External Review Procedure For Non-Mental Health/Substance Abuse Issues” provision, and the “Notice of Benefit Determination on Appeal” provision, both contained in this section of your certificate, apply.

If you or your Dependent have a grievance relating to Cigna's pharmaceutical benefit management program, you should refer to the following “Appeals Procedure” provisions. These provisions also apply to initiating this type of grievance.

**Appeals Procedure**

Cigna has a two-step appeals procedure for coverage decisions.

While a level one appeal is a required part of the process, a level two appeal is completely voluntary. For example, if a level one appeal is not resolved to your satisfaction, you may choose to make an external appeal to an Independent Panel of Mental Health Care Providers or to an Independent Review Organization, as described later in this provision, rather than pursuing Cigna’s voluntary level two appeal process.

The voluntary level two appeal review will be done without deference to the initial adverse benefit determination or to the adverse determination of a level one appeal.

The appeal review takes into account all comments, documents, records, and other information relating to the appeal that you submit, regardless of whether that information was submitted or considered: in the initial benefit determination (for a level one or a voluntary level two appeal); or during the level one appeal (for a voluntary level two appeal). Additional assistance is also available from the Vermont Department of Financial Regulation (DFR), as described later in this provision.

To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal, including any written comments, documents, records and other information relating to your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Reasonable accommodations will be made to help a person with a disability participate in the appeal process. Additionally, if English is not your primary language, we will provide you with information about how to file an appeal and how to participate in the appeal process, in your primary language, upon your request. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form. We will document the appeal for you and provide copies of that documentation to you, or to your representative.

For any appeal related to an adverse benefit determination, should a reversal of that decision be made during any step of the appeal process, Cigna will promptly authorize or otherwise arrange for coverage of a covered service that was denied or restricted. Neither you nor your treating provider will be liable for any services provided before notification to you of the adverse benefit determination and the final outcome of any appeal or independent external review. However, if your treating provider or his or her designee refuse or repeatedly fail to communicate with us, when the opportunity to communicate with us has been offered in a time and manner convenient to them, your treating provider will be liable for any services provided to you. You will not be liable in either case.
You must pay for services given by a Participating Provider or a non-Participating Provider in the event of a final denial of your claim.

Level One Appeal
Your appeal will be reviewed and the decision made by someone not involved in the initial decision. This person will also not be the subordinate of any individual who was involved with the initial decision or other issue that is the subject of the appeal. Appeals involving an adverse benefit determination that is based in whole or in part on a medical judgment will be considered by a health care professional who is a clinical peer of your treating provider.

You may request that we identify to you any clinical expert whose advice we obtained in connection with your adverse benefit determination, regardless of whether or not that expert’s advice was relied on when the determination was made. Any clinical expert we ask to consult with us regarding your level one appeal will not be the same clinical expert (if any) we consulted with regarding the adverse benefit determination that is the subject of your appeal, or the subordinate of that clinical expert (if any).

A Cigna medical director or his or her designee will offer to directly communicate with your treating provider, or your treating provider’s designee, before the appeal is decided.

You will have reasonable access to, and may obtain copies of, all documents, records and other information relevant to your appeal upon request and free of charge, within two business days. In the case of a concurrent or urgent preservice review, you will have access to or may obtain the materials immediately upon request.

Level One Urgent, Preservice Appeal
For an urgent preservice level one appeal, we will orally notify you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 72 hours after we receive the appeal. We will send written confirmation of the determination to you and your treating provider (if known), within 24 hours of our oral notification to you.

Level One Concurrent Review Appeal
For a level one appeal related to a request to continue or extend a course of treatment (i.e. a concurrent review), we will orally notify you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 24 hours after we receive the appeal. We will send written confirmation of the determination to you and your treating provider (if known), within 24 hours of our oral notification to you.

Level One Post-Service Appeal
For a level one post-service appeal, we will send written confirmation to you and your treating provider (if known) of our determination within a reasonable time period, but in no case later than 60 calendar days after we receive the appeal.

Level One Appeal Not Related to an Adverse Benefit Determination
For a level one appeal not related to an adverse benefit determination, we will send written confirmation to you within 60 calendar days after we receive the appeal.

Voluntary Level Two Appeal
If you are dissatisfied with our level one appeal decision, you may request a voluntary second review. To start a voluntary level two appeal, follow the same process required for a level one appeal. If you decide to pursue a voluntary second level appeal review, that decision has no effect on your right to any other benefits under this plan.

The voluntary level two appeal review will be done without deference to the initial adverse benefit determination or to the adverse determination of a level one appeal.

Neither you nor your provider acting on your behalf are responsible for any fees or costs associated with a voluntary level two appeal, should you choose to pursue one.

You will have reasonable access to, and may obtain copies of, all documents, records and other information relevant to your appeal.
relevant to your appeal upon request and free of charge, within two business days. In the case of a concurrent or urgent preservice review, you will have access to or may obtain the materials immediately upon request.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone who is a member of the Committee may not: have been involved in the initial adverse benefit determination or other issue that is the subject of the appeal; have been involved in the adverse determination of the level one appeal; or be the subordinate of any person involved with the initial determination or other issue that is the subject of the appeal. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer.

You may request that we identify to you any clinical expert whose advice we obtained in connection with your adverse benefit determination, regardless of whether or not that expert’s advice was relied on when the determination was made. Any clinical expert we ask to consult with us regarding your voluntary level two appeal will not be the same clinical expert (if any) we consulted with regarding the adverse benefit determination that is the subject of your appeal, or the subordinate of that clinical expert (if any).

For a voluntary level two appeal we will acknowledge in writing that we have received your request and schedule a Committee review. You will be consulted regarding setting the meeting date for a voluntary second level appeal review. You may present your situation to the Committee in person or by conference call; however, participating in person or via telephone is not a requirement for the voluntary second level appeal meeting to proceed.

**Voluntary Level Two Urgent, Preservice Appeal**

For an urgent preservice voluntary level two appeal, we will orally notify you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 72 hours after we receive the appeal. We will send written confirmation of the determination to you and your treating provider (if known), within 24 hours of our oral notification to you.

Mental health/substance abuse and pharmacy benefit requests are generally considered urgent under Vermont regulatory requirements.

**Voluntary Level Two Non-Urgent, Preservice Appeal**

For a non-urgent preservice voluntary level two appeal, we will send written confirmation to you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 30 calendar days after we receive the appeal.

**Voluntary Level Two Concurrent Review Appeal**

For a voluntary level two appeal related to a request to continue or extend a course of treatment (i.e. a concurrent review), we will orally notify you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 24 hours after we receive the appeal. We will send written confirmation of the determination to you and your treating provider (if known), within 24 hours of our oral notification to you.

**Voluntary Level Two Post-Service Appeal**

For a voluntary level two post-service appeal, we will send written confirmation to you and your treating provider (if known) of our determination within a reasonable time period, but in no case later than 60 calendar days after we receive the appeal.

**Voluntary Level Two Appeal Not Related to an Adverse Benefit Determination**

For a voluntary level two appeal not related to an adverse benefit determination, we will send written notification to you within 60 calendar days after we receive the appeal.
External Review Procedure For Mental Health/Substance Abuse Issues

If you are dissatisfied with either a Level One Appeal decision or a voluntary Level Two Appeal decision, you may request an External Review of your issue by an Independent Panel of Mental Health Care Providers (IP). To start the External Review by an IP, you, your mental health care provider or your representative on your behalf, must file a written request with Cigna and the IP. You must include your consent for Cigna to release confidential patient files to the IP. The IP address is:

Independent Panel of Mental Health Care Providers
Vermont Department of Financial Regulation (DFR)
89 Main Street
Montpelier, VT 05620-3601
800-631-7788(toll-free) or 802-282-2900

When Cigna receives your request for an External Review, Cigna will send the file supporting the initial decision and the appeal decision(s) to the IP within: 24 hours of receiving the request in emergency situations; and within five working days of receiving the request in all other situations.

The IP may address inquiries to any of the parties (you, your mental health care provider or your authorized representative, or Cigna) and may set a reasonable time period for a response. If Cigna does not provide all necessary information in the required time periods, the delay will result in a presumption in your favor and will not delay the IP’s review of the issue. The IP also has the authority to request any or all of the parties to meet with the IP. The IP will make its review decision within 24 hours of receiving all necessary information in emergency situations; and within 15 working days in all other situations. The IP will send its decision by mail or facsimile to Cigna and to the person who filed the request for External Review. Emergency decisions will be communicated by telephone, facsimile or delivered by express mail as appropriate. Cigna is required to abide by the IP’s decision. If you have a complaint about a matter that is not related to Medical Necessity or clinical appropriateness, you may file a consumer complaint with the Insurance Consumer Services Division at the following address:

Insurance Consumer Services Division
Vermont Department of Financial Regulation (DFR)
89 Main Street, Drawer 20
Montpelier, VT 05620-3101
802.828.3302

External Review Procedure For Non-Mental Health/Substance Abuse Issues

If you are dissatisfied with a level one appeal or a voluntary level two appeal decision, you may request an External Review of your issue by an Independent Review Organization (IRO).

You (or your authorized representative or your provider on your behalf) may file a written request for External Review within 90 days from the date you receive Cigna’s final, written appeal decision. External Appeals for non-Mental Health/Substance Abuse issues may be requested for the following reasons:

- The health care service is a covered benefit that Cigna has determined to be not Medically Necessary.
- A limitation is placed on the selection of a health care provider that you claimed to be inconsistent with limits imposed by this plan and any applicable laws and regulations.
- The health care treatment has been determined to be experimental or investigational or an off-label use of a drug.
• The health care service involves a medically-based decision that a condition is preexisting.

The written request for External Review must be filed with the DFR at the following address:

External Appeals Program
Vermont Department of Financial Regulation (DFR)
89 Main Street, Montpelier, VT 05620-3601
Telephone: 800-631-7788 (toll-free) or 802-828-2900

The insured must file on a form provided by the DFR and include the $25 fee or a request for a waiver or reduction of the fee, for the general release of medical records relevant to the appeal, identification of insurer and a copy of the denial level from the relevant level of appeal. An oral request will also be accepted if made within the 90-day period provided that the request is confirmed in writing on the state request form within 10 calendar days. The External Appeal program is a voluntary program.

Once notified by the DFR that the External Appeal has been accepted for review by an IRO, Cigna must submit all information relevant to the appeal, including: the review criteria used in making the decision; copies of any applicable policies or procedures; and copies of all medical records considered in making the decision in the appeal process. Cigna may request an extension of up to 10 days to submit information and documentation, granted by the DFR for good cause.

Cigna must pay the costs of the External Appeal to the DFR within 30 days of notification of the reasonable and necessary costs of the review by the IRO.

The DFR will provide the request form for an External Appeal. An oral request will also be accepted if made within the 90-day period provided that the request is confirmed in writing on the state request form within 10 calendar days. Within five working days of receiving the External Appeal request the DFR will process the form and materials, and accept the appeal for review by an IRO after determining: that you are or were insured; the service is a covered service under the plan; the External Appeal involves an appealable decision; you have exhausted the internal process; and all information has been provided.

The DFR will notify you when the External Appeal submission is complete, and whether the External Appeal has been accepted for review by an IRO. Cigna must submit any required documentation within 10 calendar days from the date Cigna receives the request notice. Cigna may request a 10-calendar day extension for good cause. You may have an extension for any reason.

The DFR shall provide copies of documentation (and follow-up information) to you and to Cigna; each will have three working days to file responsive documentation with the DFR.

The DFR will assign the External Appeal on a rotating basis to an IRO for clinical review.

The DFR will review the determination of the IRO and then issue the determination to you and to Cigna, which will be binding on Cigna but not on you.

The IRO will conduct a full review, and may request any additional information from you, Cigna, or the DFR. The IRO will complete the review, and forward its written determination to the DFR within five calendar days from receipt if the External Appeal involves emergency or urgently needed care; and 30 calendar days from receipt for all other External Appeal requests. The IRO’s written determination will include the clinical rationale for the determination. The IRO may request an extension from the Commissioner.

Additional Assistance

You have the right to contact the Health Insurance Consumer Services unit within the DFR for assistance at any time. This unit can help you if you need general information about health insurance, have concerns about our activities, or are not satisfied with how we resolved your complaint. The DFR may be contacted at the following address and telephone number:

Health Insurance Consumer Services Division
Vermont Department of Financial Regulation (DFR)
89 Main Street, Montpelier, VT 05620-3101
800-631-7788 (toll-free) or 802-828-2900

The Office of Health Care Ombudsman’s telephone hotline service can also provide help to Vermonters who have problems or questions about health care and health insurance. Contact them at:

Office of Health Care Ombudsman
264 North Winooski Avenue
Burlington, VT 05402
Telephone: 888-917-7787 or 802-863-2316
TTY: 888-884-1955 or 802-863-2473

myCigna.com
Applies to All Issues

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); and upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

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

Relevant Information

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

Definitions

Emergency Medical Condition

Emergency medical condition means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- placing the member’s physical or mental health in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Services

Emergency Services means health care items and services furnished or required to evaluate and treat an Emergency Medical Condition.

It is Cigna’s responsibility, to:

- respond to, defend against and resolve any request, or claim, by a non-Participating Provider of Emergency Services for payment exceeding the amount it was paid or reimbursed by Cigna; and
- serve as the point of contact for you, if you receive any such request or claim by a non-Participating Provider.

To obtain more information, you should call the toll-free number shown on the back of your ID card, or call us at our Customer Service/Member Services number at 1-800-351-8513.
Medically Necessary/Medical Necessity

Medically Necessary care means health care services, including diagnostic testing, preventive services and aftercare, that are appropriate in terms of type, amount, frequency, level, setting, and duration to the person’s diagnosis or condition. Medically Necessary care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition; must be informed by the unique needs of each individual patient and each presenting situation; and:

- help restore or maintain the person’s health; or
- prevent deterioration of, or palliate, the person’s condition; or
- prevent the reasonably likely onset of a health problem or detect an incipient problem.