DELUXE CORPORATION

OPEN ACCESS PLUS MEDICAL BENEFITS
High Deductible Health Plan – HRA eligible
(See Health Reimbursement Summary Plan Description)

EFFECTIVE DATE: January 1, 2018

ASO82
3173992

This document printed in May, 2018 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
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Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY DELUXE CORPORATION WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

HC-NOT89
Explanation of Terms
You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule
The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.
Special Plan Provisions
When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health 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 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.

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provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

Care Management and Care Coordination Services
Your plan may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing participants with certain care management and care coordination services to facilitate achievement of these goals. Reimbursement is provided at 100% for these services when rendered by designated health care professionals in these collaborative arrangements.

Important Information
Rebates and Other Payments
Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals covered under your plan. These rebates or remuneration are not obtained on you or your Employer’s or plan’s behalf or for your benefit. Cigna, its affiliates and the plan are not obligated to pass these rebates on to you, or apply them to your plan’s Deductible if any or take them into account in determining your Copayments and/or Coinsurance. Cigna and its affiliates or designees, conduct business with various pharmaceutical manufacturers separate and apart from this plan’s Medical Pharmaceutical benefits. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this plan. Cigna and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.
Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Cigna:

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

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

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

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

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

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

How To File Your Claim

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

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

CLAIM REMINDERS

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

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**Eligibility - Effective Date**

**Employee Insurance**

This plan is offered to you as an Employee.

**Eligibility for Employee Insurance**

You will become eligible for insurance if you are:

- an active Full-Time Employee;
- a Part-Time Employee regularly scheduled to work 20 or more hours per week; or
- an Eligible, pre-65, qualified retiree.

This does not include seasonal or temporary Employees, or independent contractors.

You become eligible for the medical plan on the first day of the month following your date of hire or when you become otherwise eligible based on your regularly scheduled work week.

You have 30 days to enroll. If you do not enroll within 30 days you will default into “No Coverage” and you will not be able to enroll again until the next annual enrollment period, unless you experience a qualified Life Status Change.

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 13 consecutive weeks 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.

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**Waiting Period**

The first day of the month following your date of hire or when you become otherwise eligible based on your regularly scheduled work week.

**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 first day of the month following your date of hire, or when you become otherwise eligible based on your regularly scheduled work week.

**Late Entrant - Employee**

You are a Late Entrant if:

- you elect the insurance more than 31 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, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you elect Dependent coverage, YBR will automatically require certification. You will receive a letter requesting documents to certify your dependent's eligibility. Documents include marriage certificates, birth certificates, tax returns. Documents must be provided within 31 days of the enrollment effective date. If documents are not received and approved by the deadline, your dependents will not be eligible and coverage will be terminated.

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 31 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
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.
**Open Access Plus Medical Benefits**

**The Schedule**

**For You and Your Dependents**

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

When you receive services from an In-Network Provider, remind your provider to utilize In-Network Providers for x-rays, lab tests and other services to ensure the cost may be considered at the In-Network level.

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.

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**Coinsurance**

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

**Deductibles**

Deductibles are expenses to be paid by you or your Dependent. 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.

**Out-of-Pocket Expenses - For In-Network Charges Only**

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles 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%.

**Out-of-Pocket Expenses - For Out-of-Network Charges Only**

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%:

- Coinsurance.
- Plan Deductible.

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Non-compliance penalties.
- Any benefit deductibles.
- Provider charges in excess of the Maximum Reimbursable Charge.

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**Accumulation of Plan Deductibles and Out-of-Pocket Maximums**

Deductibles and Out-of-Pocket Maximums will cross-accumulate (that is, In-Network will accumulate to Out-of-Network and Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) also cross-accumulate between In- and Out-of-Network unless otherwise noted.
Open Access Plus Medical Benefits
The Schedule

Accumulation of Pharmacy Benefits
If your plan provides Pharmacy benefits separately, any In-Network medical Out-of-Pocket Maximums will cross accumulate with any In-Network Pharmacy Out-of-Pocket Maximums.

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

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon
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.)

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

Out-of-Network Emergency Services Charges

1. Emergency services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.

2. The allowable amount used in determining benefit payments for covered emergency services provided in the emergency department of a non-participating (Out-of-Network) Hospital is the negotiated amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed upon, the greater of the following:
   (i) the median amount negotiated with In-Network providers for the emergency service (excluding In-Network copay or coinsurance);
   (ii) the Maximum Reimbursable Charge;
   (iii) the amount payable under the Medicare program (not to exceed the provider’s billed charges).

The member is responsible for the applicable In-Network cost-sharing amounts. The member also is responsible for all charges in excess of the allowable amount unless a negotiated amount is agreed to by the Out-of-Network provider and Cigna.

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>The Percentage of Covered Expenses the Plan Pays</td>
<td>80%</td>
<td>55% of the Maximum Reimbursable Charge</td>
</tr>
</tbody>
</table>

| Note: "No charge" means an insured person is not required to pay Coinsurance. |
### Maximum Reimbursable Charge

Maximum Reimbursable Charge is determined based on the lesser of the provider’s normal charge for a similar service or supply; or

A percentage of a schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider’s normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company.

**Note:**
The provider may bill you for the difference between the provider’s normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles and coinsurance.

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

<table>
<thead>
<tr>
<th>Benefit Highlights</th>
<th>In-Network</th>
<th>Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Reimbursable Charge</td>
<td>Not Applicable</td>
<td>200%</td>
</tr>
</tbody>
</table>
## BENEFIT HIGHLIGHTS

### IN-NETWORK

#### Calendar Year Deductible
- **Individual**
  - Deductible: $1,500 per person
- **Family Maximum**
  - Deductible: $3,000 per family

#### Family Maximum Calculation

- **Collective Deductible:**
  - All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.

#### Out-of-Pocket Maximum
- **Individual – Employee Only**
  - Maximum: $3,800 per person
- **Individual – within a Family**
  - Maximum: $6,850 per person
- **Family**
  - Maximum: $7,600 per family

#### Family 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%.

### OUT-OF-NETWORK

#### Primary Care Physician’s Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>85% (CCN) or 75% (Non-CCN) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Surgery Performed in the Physician’s Office</td>
<td>85% (CCN) or 75% (Non-CCN) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Second Opinion Consultations (provided on a voluntary basis)</td>
<td>85% (CCN) or 75% (Non-CCN) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Allergy Treatment/Injections</td>
<td>85% (CCN) or 75% (Non-CCN) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Allergy Serum (dispensed by the Physician in the office)</td>
<td>85% (CCN) or 75% (Non-CCN) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
</tbody>
</table>

### Note:

- **80% coinsurance provision applies in-network for anyone in the HealthPartners service area.**

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<table>
<thead>
<tr>
<th>Specialty Care Physician Services</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: ** 80% coinsurance provision applies in-network for anyone in the HealthPartners service area. OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.</td>
<td>85% (CCN) or 75% (Non-CCN) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Office Visits Consultant and Referral Physician’s Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery Performed by a Specialist in the Physician’s Office</td>
<td>85% (CCN) or 75% (Non-CCN) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Second Opinion Consultations performed by a Specialist (provided on a voluntary basis)</td>
<td>85% (CCN) or 75% (Non-CCN) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Allergy Treatment/Injections performed by a Specialist</td>
<td>85% (CCN) or 75% (Non-CCN) after plan deductible</td>
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<td>55% after plan deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit. Routine Preventive Care - all ages</td>
<td>No charge</td>
<td>No charge (Note: Only the lab charges are to be covered and no other charges for Out-of-Network preventive are covered.)</td>
</tr>
<tr>
<td>Immunizations - all ages Note: Includes school physicals exams and immunizations for school and travel abroad.</td>
<td>No charge</td>
<td>No charge (Note: Only the lab charges are to be covered and no other charges for Out-of-Network preventive are covered.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mammograms, PSA, PAP Smear</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Related Services (i.e. “routine” services)</td>
<td>No charge</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Diagnostic Related Services (i.e. “non-routine” services)</td>
<td>Subject to the plan’s x-ray &amp; lab benefit; based on place of service</td>
<td>Subject to the plan’s x-ray &amp; lab benefit; based on place of service</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td><strong>Inpatient Hospital - Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-Private Room and Board</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>Limited to the semi-private room</td>
<td>Limited to the semi-private room rate</td>
</tr>
<tr>
<td></td>
<td>negotiated rate</td>
<td></td>
</tr>
<tr>
<td>Private Room</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>Limited to the semi-private room</td>
<td>Limited to the semi-private room rate</td>
</tr>
<tr>
<td></td>
<td>negotiated rate</td>
<td></td>
</tr>
<tr>
<td>Special Care Units (ICU/CCU)</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>Limited to the semi-private room</td>
<td>Limited to the ICU/CCU daily room</td>
</tr>
<tr>
<td></td>
<td>negotiated rate</td>
<td>rate</td>
</tr>
</tbody>
</table>

| **Outpatient Facility Services**           |                                      |                                      |
| Operating Room, Recovery Room, Procedures | 80% after plan deductible            | 55% after plan deductible            |
| Room, Treatment Room and Observation Room  |                                      |                                      |

<table>
<thead>
<tr>
<th><strong>Inpatient Hospital Physician’s Visits/Consultations</strong></th>
<th>55% after plan deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Physician’s Visits/Consultations</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
</tr>
</tbody>
</table>

| **Inpatient Hospital Professional Services**          |                                      |                                      |
| Surgeon                                                | 85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible |
|                                                       | 55% after plan deductible            |
| Radiologist                                            | 75% after plan deductible            |
| Pathologist                                            | 55% after plan deductible            |
| Anesthesiologist                                       | 55% after plan deductible            |

<p>| <strong>Outpatient Professional Services</strong>                 |                                      |                                      |
| Surgeon                                                | 85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible |
|                                                       | 55% after plan deductible            |
| Radiologist                                            | 75% after plan deductible            |
| Pathologist                                            | 55% after plan deductible            |
| Anesthesiologist                                       | 55% after plan deductible            |</p>
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
</tr>
<tr>
<td>Urgent Care Facility or Outpatient Facility</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Professional Services (radiology, pathology, physician)</td>
<td>75% after plan deductible</td>
<td>75% 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>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRA, CAT Scans, PET Scans etc.)</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Professional Services (radiology, pathology, ER physician)</td>
<td>75% after plan deductible</td>
<td>75% after plan deductible</td>
</tr>
<tr>
<td>X-ray and/or Lab performed at the Emergency Room Facility (billed by the facility as part of the ER visit)</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td>Independent X-ray and/or Lab Facility in conjunction with an ER visit</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRA, CAT Scans, PET Scans etc.)</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td><strong>Inpatient Services at Other Health Care Facilities</strong></td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum: 100 days combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------</td>
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<td>----------------</td>
</tr>
</tbody>
</table>
| Laboratory and Radiology Services  
(includes pre-admission testing) | 85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible | 55% after plan deductible |
<p>| Physician’s Office Visit | 85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible | 55% after plan deductible |
| Outpatient Hospital Facility | 80% after plan deductible | 55% after plan deductible |
| Independent X-ray and/or Lab Facility | 80% after plan deductible | 55% after plan deductible |
| Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans) | 85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible | 55% after plan deductible |
| Physician’s Office Visit | 85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible | 55% after plan deductible |
| Inpatient Facility | 80% after plan deductible | 55% after plan deductible |
| Outpatient Facility | 80% after plan deductible | 55% after plan deductible |
| Outpatient Short-Term Rehabilitative Therapy | 80% after plan deductible | 55% after plan deductible |
| Calendar Year Maximum: 60 days for all therapies combined | Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy | |
| Outpatient Cardiac Rehabilitation | 80% after plan deductible | 55% after plan deductible |
| Calendar Year Maximum: 36 days | | |
| Chiropractic Care | 80% after plan deductible | 55% after plan deductible |
| Calendar Year Maximum: 24 days | | |
| Physician’s Office Visit | | |
| Home Health Care | 80% after plan deductible | 55% after plan deductible |
| Calendar Year Maximum: 60 days (includes outpatient private nursing when approved as Medically Necessary) | | |
| (The limit is not applicable to Mental Health and Substance Use Disorder conditions.) | | |</p>
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Services (same coinsurance level as Home Health Care)</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td><strong>Bereavement Counseling</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services provided as part of Hospice Care</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Inpatient</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Services provided by Mental Health Professional</td>
<td>Covered under Mental Health Benefit</td>
<td>Covered under Mental Health Benefit</td>
</tr>
<tr>
<td><strong>Maternity Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Visit to Confirm Pregnancy</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td><strong>Note:</strong> OB/GYN providers will be considered either as a PCP or Specialist depending on how the provider contracts with the Insurance Company.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All subsequent Prenatal Visits, Postnatal Visits and Physician’s Delivery Charges (i.e. global maternity fee)</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>55% after plan deductible</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>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Delivery - Facility (Inpatient Hospital, Birthing Center)</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td><strong>Abortion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes only non-elective procedures</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
</tbody>
</table>
### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Women’s Family Planning Services</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits, Lab and Radiology Tests and Counseling</td>
<td>No charge</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td><strong>Note:</strong> 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. Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)</td>
<td>No charge</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>No charge</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>No charge</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>No charge</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>No charge</td>
<td>55% after plan deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Men’s Family Planning Services</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits, Lab and Radiology Tests and Counseling</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Surgical Sterilization Procedures for Vasectomy (excludes reversals)</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Infertility Treatment Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Not Covered include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Testing performed specifically to determine the cause of infertility.</td>
<td></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>
<td></td>
</tr>
<tr>
<td>• Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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>
<td></td>
</tr>
<tr>
<td>Organ Transplants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes all medically appropriate, non-experimental transplants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>85% (CCN PCP/Specialist) or 75%</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>(Non-CCN PCP/Specialist) after plan deductible</td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100% at Lifesource center, otherwise 80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100% at Lifesource center, otherwise 85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>55% after plan deductible up to specific organ transplant maximum:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heart - $150,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Liver - $230,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bone Marrow - $130,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heart/Lung - $185,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lung - $185,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pancreas - $50,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kidney - $80,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kidney/Pancreas - $80,000</td>
</tr>
<tr>
<td>Lifetime Travel Maximum:</td>
<td>No charge (only available when using Lifesource facility)</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>$10,000 per transplant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>Breast Feeding Equipment and Supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Includes the rental of one breast</td>
<td>No charge</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>pump per birth as ordered or prescribed by</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a physician. Includes related supplies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>External Prosthetic Appliances</strong></td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nutritional Evaluation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 visits per person however, the 3 visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>limit will not apply to treatment of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mental health and substance use disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>conditions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>85% (CCN PCP/Specialist)</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>85% (CCN PCP/Specialist)</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Dental Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to charges made for a continuous</td>
<td>85% (CCN PCP/Specialist)</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>course of dental treatment started within</td>
<td>or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td></td>
</tr>
<tr>
<td>six months of an injury to teeth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>85% (CCN PCP/Specialist)</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>85% (CCN PCP/Specialist)</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td></td>
<td>or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
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<tr>
<td>--------------------</td>
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</tr>
<tr>
<td><strong>Bariatric Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Subject to any limitations shown in the “Exclusions, Expenses Not Covered and General Limitations” section of this certificate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>80% after plan deductible</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>80% after plan deductible</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>85% (CCN PCP/Specialist) or 75% (Non-CCN PCP/Specialist) after plan deductible</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td><strong>Routine Foot Disorders</strong></td>
<td>Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.</td>
<td>Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.</td>
</tr>
<tr>
<td><strong>Treatment Resulting From Life Threatening Emergencies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Acute Inpatient and Residential Treatment</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
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<tr>
<td>Outpatient - Office Visits</td>
<td>85% after plan deductible</td>
<td>55% after plan deductible</td>
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<td>Includes individual, family and group psychotherapy; medication management, etc.</td>
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<td>Calendar Year Maximum: Unlimited</td>
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<tr>
<td>Outpatient - All Other Services</td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
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<td>Includes Partial Hospitalization, Intensive Outpatient Services, etc.</td>
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<td>Calendar Year Maximum: Unlimited</td>
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<tr>
<td>Benefit Highlights</td>
<td>In-Network</td>
<td>Out-Of-Network</td>
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<td><strong>Substance Use Disorder</strong></td>
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<td><strong>Inpatient</strong></td>
<td>80% after plan deductible</td>
<td>55% after plan deductible</td>
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<tr>
<td>Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment</td>
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Open Access Plus Medical Benefits

Certification Requirements - Out-of-Network
For You and Your Dependents

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

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

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

Covered Expenses incurred will be reduced by 20% for Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission.

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

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

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

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

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

Covered Expenses incurred will be reduced by 20% for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

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

Diagnostic Testing and Outpatient Procedures
Including, but not limited to:

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

Prior Authorization/Pre-Authorized
The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- outpatient facility services;
- Partial Hospitalization;
- advanced radiological imaging;
- non-emergency ambulance;
- certain Medical Pharmaceuticals; 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 Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The 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 anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- abortion when a Physician certifies in writing that the pregnancy would endanger the life of the mother, or when the expenses are incurred to treat medical complications due to abortion.
- 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 for the delivery of health-related services and information via telecommunications technologies, including telephones and “Skype Like” consultations via personal computers or smart phones, when delivered through a contracted telehealth provider.
Clinical Trials
This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

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

(b) either

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

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

The clinical trial must meet the following requirements:

The study or investigation must:

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

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

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

Routine patient care costs do not include:

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

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

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

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 calendar year for both pre- and post-genetic testing. The visit limit does not apply to genetic counseling related to treatment of mental health and/or substance use disorders.

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 Care Services
- charges made for Home Health Care 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 Care Services are provided under the terms of a Home Health Care plan for the person named in that plan.
If you are a minor or an adult who is dependent upon others for nonskilled care (e.g. bathing, eating, toileting), Home Health Care Services will only be provided for you during times when there is a family member or care giver present in the home to meet your nonskilled care needs.

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 Use Disorder Services

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

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

Inpatient Mental Health Services

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

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

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

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

Inpatient Substance Use Disorder Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Residential Treatment services.
Substance Use Disorder Residential Treatment Services
are services provided by a Hospital for the evaluation and
treatment of the psychological and social functional
disturbances that are a result of subacute Substance Use
Disorder conditions.

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

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

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

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

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

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

Durable Medical Equipment
• charges made for the purchase or rental of Durable Medical
  Equipment which is ordered or prescribed by a provider and
  provided by a vendor approved by Cigna. Coverage for the
  repair, replacement or duplicate equipment is not covered
  except when replacement or revision is necessary due to
  growth or a change in medical condition.

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

Unless covered in connection with the services described in
another section of this certificate, the following are
specifically excluded:
• Hygienic or self-help items or equipment;
• Items or equipment that are primarily used for comfort or
  convenience, such as bathtub chairs, safety grab bars, stair
  gliders or elevators, over-the-bed tables, saunas or exercise
  equipment;
• Environmental control equipment, such as air purifiers,
  humidifiers and electrostatic machines;
• Institutional equipment, such as air fluidized beds and
  diathermy machines;
• Elastic stockings and wigs;
• Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, orthotics, braces and splints;
• Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
• Items which under normal use would constitute a fixture to real property, such as ramps, railings, and grab bars.

Coverage is subject to the maximum shown in The Schedule.

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• charges made for the initial purchase and fitting of external prosthetic devices which are used as replacements or substitutes for missing body parts and are necessary to alleviate or correct Sickness, Injury or congenital defect; including only artificial arms and legs and terminal devices such as hands or hooks. Replacement of such prostheses is covered only if needed due to normal anatomical growth.

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Short-Term Rehabilitative Therapy
• charges made for Short-term Rehabilitative Therapy which is a part of a rehabilitative program, including physical, speech, occupational, and pulmonary rehabilitation therapy, when provided in the most medically appropriate inpatient or outpatient setting.

The following limitations apply to Short-Term Rehabilitative Therapy Services:
• occupational therapy is provided only for purposes of training members to perform the activities of daily living;
• speech therapy is not covered when used to improve speech skills that have not fully developed; considered custodial or educational; intended to maintain speech communication; or not restorative in nature.

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

The following limitations apply to Chiropractic Care Services:
• to be covered all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designated to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.
• services are not covered if they are custodial, training, educational or developmental in nature.
• occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Chiropractic Care Services that are not covered include but are not limited to:
• services of a chiropractor which are not within his scope of practice, as defined by state law;
• charges for care not provided in an office setting;
• maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient’s current status; and
• vitamin therapy.

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Breast Reconstruction and Breast Prostheses
• charges made for reconstructive surgery following a mastectomy, if the insured chooses to have surgery, and in the manner chosen by the insured and Physician. Services and 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.

Cosmetic Surgery
Charges made for cosmetic surgery or therapy to repair or correct severe facial disfigurements or severe physical deformities that are congenital or result from developmental abnormalities (other than abnormalities of the jaw or TMJ
disorder), tumors, trauma, disease or the complications of Medically Necessary non-cosmetic surgery.

Reconstructive surgery for correction of congenital birth defects or developmental abnormalities must be performed prior to your attainment of age 19. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by Cigna.

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 covered at the Out-of-Network level.

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

Transplant Travel Services

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

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

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

Medical Pharmaceuticals

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

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

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

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

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

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.

- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.

- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
• for or in connection with experimental, investigational or unproven services.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

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

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

• cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.

The following services are excluded from coverage regardless of clinical indications: rhinoplasty; blepharoplasty; acupressure; dance therapy, movement therapy; applied kinesiology; rolfing; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

• surgical or non-surgical 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 made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.
• for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung, and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:

• 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.

• 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.

• Services for the treatment of Autism Spectrum Disorder.
• Payment is excluded for intensive behavior treatment of autism including but not limited to applied behavior analysis, Lovaas therapy, Floortime, Relationship Development Intervention.

• non-medical counseling and/or ancillary services, including but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis,

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sleep therapy, return to work services, work hardening programs and driver safety courses.

- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.

- private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.

- personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.

- 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 non-verbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.

- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).

- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

- treatment by acupuncture.

- all non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.

- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

- dental implants for any condition.

- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

- blood administration for the purpose of general improvement in physical condition.

- cost of biologicals that are medications for the purpose of travel, or to protect against occupational hazards and risks.

- cosmetics, dietary supplements and health and beauty aids.

- all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.

- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a non-Participating Provider.

- medical treatment when payment is denied by a Primary Plan because treatment was received from a non-Participating Provider.

- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.

- charges for the delivery of health-related services and information via telecommunications technologies, including telephones and “Skype Like” consultations via personal computers or smart phones, unless provided as specifically described under Covered Services.

- massage therapy.

- abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.

- gender reassignment surgery.
General Limitations
No payment will be made for expenses incurred for you or any one of your Dependents:

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your 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.

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 which limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

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

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

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

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

- The Plan that covers a person as an enrollee or an employee shall be the Primary Plan and the Plan that covers that person as a Dependent shall be the Secondary Plan;
- For 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;
- For 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 noncustodial parent of the child, and
- finally, the Plan of the spouse of the parent not having custody of the child.

The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

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, this paragraph shall not apply.

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

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

**Recovery of Excess Benefits**

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

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

**Right to Receive and Release Information**

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

**Medicare Eligibles**

Cigna will pay as the Secondary Plan as permitted by the 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) a retired Employee 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 former Employee and his Dependent unless he is listed under (a) through (c) 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. The coverage under this plan is secondary to any automobile no-fault or similar 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 adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan’s right to recover shall apply to decedents’, minors’, and incompetent or disabled persons’ settlements or recoveries.

- 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”.

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• 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.

• The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan’s subrogation or recovery rights are neither affected nor diminished by equitable defenses.

• 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.

• Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

Payment of Benefits

Assignment and Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

You may, however, authorize Cigna to pay any healthcare benefits under this policy to a Participating or Non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or Non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider’s responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Services directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or Non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a Non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the Non-Participating 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. In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

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.
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 date as determined by your Employer, 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. However, your insurance will not continue past the date your Employer cancels your insurance.

Retirement
If your Active Service ends because you retire, and you are under age 65, your insurance will be continued until the earlier of: a) the date on which your Employer cancels the insurance; or b) your 65th birthday.

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 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.

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.

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

Qualified Medical Child Support Order (QMCSO)
Eligibility for Coverage Under a QMCSO
If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as
required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

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

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

### 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 31 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
Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the “Newborns’ and Mothers’ Health Protection Act”: restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

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

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

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.

Reinstatement of Benefits (applicable to all coverages)
If your coverage ends during the leave of absence because you do not elect USERRA 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 under ERISA
The following complies with federal law. Provisions of applicable laws of your state may supersede.

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

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

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

Preservice Determinations
When you or your representative requests a required prior authorization, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna’s control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more 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 health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna will defer to the determination of the treating health care professional regarding whether an expedited determination is necessary. Cigna 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 determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

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

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

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days.
after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the 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 including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan’s review procedures and the time limits applicable, including a statement of a claimant’s rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, (if applicable); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; a description of any available internal appeal and/or external review process(es); information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

**Appointment of Authorized Representative**

You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However, Cigna may require you to designate your authorized representative in writing using a form approved by Cigna. At all times, the appointment of an authorized representative is revocable by you. To ensure that a prior appointment remains valid, Cigna may require you to re-appoint your authorized representative, from time to time.

Cigna reserves the right to refuse to honor the appointment of a representative if Cigna reasonably determines that:

- the signature on an authorized representative form may not be yours, or
- the authorized representative may not have disclosed to you all of the relevant facts and circumstances relating to the overpayment or underpayment of any claim, including, for example, that the billing practices of the provider of medical services may have jeopardized your coverage through the waiver of the cost-sharing amounts that you are required to pay under your plan.

If your designation of an authorized representative is revoked, or Cigna does not honor your designation, you may appoint a new authorized representative at any time, in writing, using a form approved by Cigna.

**Medical - When You Have a Complaint or an Appeal**

For the purposes of this section, any reference to "you" or "your" 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 may call the toll-free number on your ID card, explanation of benefits, or claim form and explain your concern to one of our Customer Service representatives. You may also express that concern in writing.

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 may start the appeals procedure.

**Internal Appeals Procedure**

To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 180 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 Cigna to register your appeal by telephone. Call or write us at the toll-free number on your ID card, explanation of benefits, or claim form.

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.

We will respond in writing with a decision within 30 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination or a postservice Medical Necessity determination. We will respond within 60 calendar days after we receive an appeal for any other 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.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, this information will be provided automatically 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 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 retain maximum functionality or in the opinion of your health care provider 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 review at the same time, if the time to complete an expedited review would be detrimental to your medical condition.

When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

**External Review Procedure**

If you are not fully satisfied with the decision of Cigna's internal appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate an external review. Cigna and your benefit plan will abide by the decision of the IRO.

To request a review, you must notify the Appeals Coordinator within 4 months of your receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna's 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 a facility, the external 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 including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific plan provisions on which the determination is based; a 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 below; 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), if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your 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 an 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 for
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 appeal processes. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services or within three years after proof of claim is required under the Plan for Out-of-Network services.

HC-FED82 03-14

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?
Under federal law, your Dependents must be given the opportunity to continue health insurance when there is a “qualifying event” that would result in loss of coverage under the Plan. 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. Your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?
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: 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).

Medicare Extension for Your Dependents
If you retire and you became enrolled in Medicare (Part A, Part B or both) within the 18 months retirement, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare.

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 your Dependents move out of the Employer’s service area or the Employer eliminates a service area in their location, their COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available 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 Employer’s location, they may elect COBRA continuation coverage under that option.

Employer’s Notification Requirements
Your former 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
similarly situated active Employee or family member. Employer and Employee contributions) for coverage of a 102% of the cost to the group health plan (including both cost

Each qualified beneficiary may be required to pay the entire How Much Does COBRA Continuation Coverage Cost?

If your Dependent(s) experience one of the following qualifying events, you or your Dependents 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.

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

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 or your Dependents must notify the Plan Administrator of the 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 proper notification is not made by the due date shown on the notice, your Dependents will lose the right to elect COBRA continuation coverage. If COBRA continuation coverage is rejected before the due date, your Dependents may change their mind as long as they furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries.

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.

- 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 or your Dependents must notify the Plan Administrator of the 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 proper notification is not made by the due date shown on the notice, your Dependents will lose the right to elect COBRA continuation coverage. If COBRA continuation coverage is rejected before the due date, your Dependents may change their mind as long as they furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries.

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.
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, 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.

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

Interaction With Other Continuation Benefits
You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

ERISA Required Information
The name of the Plan is:
Deluxe Corporation Comprehensive Welfare Benefit Plan
The name, address, ZIP code and business telephone number of the sponsor of the Plan is:
Deluxe Corporation
3680 N. Victoria St.
Shoreview, MN 55126-2966
(651) 483-7111
Employer Identification Number (EIN): 410216800
Plan Number: 660
The name, address, ZIP code and business telephone number of the Plan Administrator is:
Employer named above
The name, address and ZIP code of the person designated as agent for service of legal process is:
Employer named above
The office designated to consider the appeal of denied claims is:
The Cigna Claim Office responsible for this Plan
The cost of the Plan is shared by Employee and Employer.
The Plan’s fiscal year ends on 12/31.
The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.
Plan Trustees
A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.
Plan Type
The plan is a healthcare benefit plan.
Collective Bargaining Agreements
You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.
Discretionary Authority
The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.
Plan Modification, Amendment and Termination
The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of
any participant is required to terminate, modify, amend or change the Plan.

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

Your coverage under the Plan’s insurance policy(s) will end on the earliest of the following dates:
- the date you leave Active Service (or later as explained in the Termination Section);
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

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

Statement of Rights

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

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

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 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.

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

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

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

Charges
The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount.
Chiropractic Care
The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Cigna Care Network (CCN)
The term Cigna Care Network (CCN) refers to a designation given to Participating Providers who meet independently-established criteria determining efficiency and quality.

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.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

Proof of the child’s condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild or a child for whom you are the legal guardian, or a child eligible to be claimed on your tax return and residing with you in a parent/child relationship for at least 50% of the year. 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 date as determined by your Employer.

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 YBR 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 YBR 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.

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**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.

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**Employee**

The term Employee means an employee of the Employer who is regularly scheduled to work 20 or more hours per week and is currently in Active Service. The term does not include temporary employees, seasonal employees, or independent contractors.

**Employer**

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf Cigna is providing claim administration services.

**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 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.

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.

Hospital
The term Hospital means:

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

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

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

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.
Injury
The term Injury means an accidental bodily injury.

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.

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

Maximum Reimbursable Charge - Medical
The Maximum Reimbursable Charge for covered services is determined based on the lesser of:
• the provider’s normal charge for a similar service or supply; or
• a policyholder-selected percentage of a schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule.
In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:
• the provider’s normal charge for a similar service or supply; or
• the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

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.

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

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

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

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

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

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

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

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

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

Patient Protection and Affordable Care Act of 2010 ("PPACA")
Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).
Pharmacy & Therapeutics (P&T) Committee
A committee comprised of both voting and non-voting Cigna-employed clinicians, Medical Directors and Pharmacy Directors and non-employees such as Participating Providers that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by the Business Decision Team. The P&T Committee’s review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

Physician
The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:
- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Prescription Drug List
A list that categorizes drugs, Biologics (including Biosimilars) or other products covered under the plan’s Prescription Drug benefits that have been approved by the U.S. Food and Drug Administration (FDA). This list is developed by Cigna’s Business Decision Team based on clinical factors communicated by the P&T Committee, and adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan.

Prescription Drug Product
A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the plan, this definition also includes:
- The following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips;
- Needles and syringes for self-administered medications or Biologics covered under the plan’s Prescription Drug benefit; and
- Inhaler assistance devices and accessories, peak flow meters.

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

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

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

**Review Organization**

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

**Sickness – For Medical Insurance**

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

**Skilled Nursing Facility**

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

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis; but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

**Specialist**

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

**Specialty Prescription Drug Product**

A Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Medical Pharmaceutical has a high acquisition cost; and, whether the Medical Pharmaceutical is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

**Stabilize**

Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

**Terminal Illness**

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.
**Therapeutic Alternative**
A Medical Pharmaceutical that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another Medical Pharmaceutical or over-the-counter medication.

**Therapeutic Equivalent**
A Medical Pharmaceutical that is a pharmaceutical equivalent to another Medical Pharmaceutical or over-the-counter medication.

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

The prescription drug benefit is provided by Express Scripts to individuals who are covered under Deluxe Corporation Plan. If you are enrolled in the Plan, you are eligible for the prescription drug program through Express Scripts.

Express Scripts Contact Information:
Express Scripts
1 (855) 778-1418
www.express-scripts.com

Benefits Highlights
The table below provides an overview of the Plan's Prescription Drug coverage. It includes Copay amounts that apply when you have a prescription filled at a Network Pharmacy.

Coverage of required ACA Preventive items & Services are included under your prescription benefit.

Copay Plan and Coinsurance Plan

**Cigna HRA:**

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<th>Deductible</th>
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<td>Out of-network: $2,400 Individual /$4,800 Family (Rx/Medical Integrated)</td>
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<tr>
<th>Out of Pocket</th>
<th>In-network: $3,800 Individual / $7,600 Family (Rx/Medical Integrated)</th>
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<tbody>
<tr>
<td>Out of-network: $6,200 Individual/$12,400 Family (Rx/Medical Integrated)</td>
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<tr>
<th>Retail (up to 30-day supply)</th>
<th>In-Network</th>
<th>Out of Network</th>
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<tbody>
<tr>
<td>Generic</td>
<td>20% coinsurance</td>
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<tr>
<td>Preferred Brand Drugs</td>
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<th>Mail Order &amp; Retail (up to 90-day supply)</th>
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**Member Services**

Visit Express Scripts website, [Error! Hyperlink reference not valid.](www.express-scripts.com), to view your plan design, locate a participating pharmacy near you, and manage your home delivery prescriptions. For additional Plan inquiries, you may call Member Services directly at 1-855-778-1418. For future reference, this number is listed on the back of your Express Scripts ID card.
Benefit ID Cards
Express Scripts will provide an initial benefit ID card upon enrollment in the plan. Present your ID card when filling a prescription at a Network Pharmacy. Should you need additional or replacement ID cards, please contact Member Services at 1-855-778-1418 or visit www.express-scripts.com to either request a new card or print a temporary card.

Network Retail Pharmacies
The Express Scripts Pharmacy Network is a national network comprised of over 60,000 retail pharmacies. The network includes most major chains, discount, grocery and independent pharmacies, so there is a good chance that your local pharmacy is a participating member of the network. To find a local pharmacy, visit www.express-scripts.com or contact Member Services.

Covered Expenses
- Most Brand name or generic drugs requiring a prescription under Federal law (or applicable state law).
- Diabetic supplies such as test strips, lancets, syringes and needles.
- Contraceptives (oral, transdermal, intravaginal, Emergency kit, Injectable (age restrictions may apply)
- Smoking Cessation (age restrictions may apply)

Mail Order
The Express Scripts Mail Order Pharmacy provides up to a 90-day supply of medication, delivered directly to your home or other requested location, postage paid. To fill your prescription through the Express Scripts Mail Order Pharmacy, ask your doctor to fax your prescription by calling Member Services at 1-855-778-1418 for further instruction. Your medication will usually be delivered within 7-10 days of Express Scripts receiving your order.

If a new medication has been prescribed for you to take immediately, please ask your doctor to issue two prescriptions; one prescription should be written for a 30-day supply and filled at your local pharmacy and the second should be written for up to a 90-day supply and ask your doctor to fax the 90-day prescription to Express Scripts by calling Member Services at 1-855-778-1418.

To ensure timely delivery, please place your orders at least two weeks in advance to allow for mail delays and other circumstances beyond our control. If you have any questions concerning your order, please contact Member Services.

As you manage your prescriptions, please be aware that each and every prescription is filled and checked by highly qualified registered pharmacists to ensure that quantity, quality and strength are accurate. A patient profile is maintained on file to ensure that there are no adverse reactions with other prescriptions you are receiving from retail and/or mail order pharmacies. If any questions arise regarding potential drug interactions or other adverse reactions, Express Scripts pharmacists will contact either you or your doctor prior to dispensing the medication.

Coverage limits
The Plan may have certain coverage limits. For example, a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period.

Quantity / Dose Limitations
Certain medication classes may have quantity limits based on FDA and manufacturer guidelines.
Prior Authorization
Some medications may not be covered unless you receive approval through a prior authorization coverage review.

In addition, certain Non-Preferred medications will be covered only if you get prior approval through a coverage review. If you fill a prescription for one of the medications without getting prior approval, you’ll be responsible for the drug’s entire cost. Please contact Member Services at 1-855-778-1418 or visit www.express-scripts.com to determine a drug’s coverage.

Step Therapy
You may be required to try one or more equally effective front-line drugs (typically generic) to treat a medical condition before the plan will cover another, usually more expensive, drug. Please contact Express Scripts Member Services at 1-855-778-1418 for more information.

Specialty Pharmacy Services
The Plan Sponsor reserves the right to require that certain medications be purchased only through the specialty pharmacy. Express Scripts provides specialty pharmacy services for patients with certain complex and chronic conditions through Express Scripts. Confidential and convenient delivery with packaging and handling protocols designed so medication arrives with integrity intact.

- Confidential and convenient delivery with packaging and handling protocols designed so medication arrives with integrity intact.
- Clinical services to assist the patient—under the supervision of his/her physician—in implementing the prescribed course of treatment.
- Compliance programs to promote patient persistency and help the patient improve his/her quality of life.

Direct Claims
Your Plan provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. Pharmacy claims must be submitted within 365 days of the date of service to be eligible for reimbursement. This claim will be processed based on your Plan benefit. To request reimbursement you will send your claim to Express Scripts Attn: Commercial Claims P.O. Box 14711 Lexington, KY 40512-4711. If your claim is denied, you will receive a written notice, as long as all needed information was provided with the claim. You will be notified if additional information is needed to process the claim.

Expenses Not Covered
No payment will be made under any portion of the Plan for:

- Over-the-counter (OTC) drugs;
- A drug that is available both OTC and as a prescription item in exactly the same dosage strength and form;
- Therapeutic devices or appliances, support garments and other non-medical devices;
- Medication that is to be taken by or administered to a Plan participant, in whole or in part, while the Plan participant is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution that operates on its premises a facility for dispensing pharmaceuticals;
- Investigational or experimental drugs
- Prescriptions that a Plan participant is entitled to receive without charge under any Worker’s Compensation law or any municipal state or federal program;
• Insulin Pumps
• Drugs to treat Impotency / Yohimbine
• Fertility
• Anti-obesity drugs
• Nutritional Supplements and Combo Nutritional Products
• Medical Foods, Infant Formulas Rx & OTC
• Ostomy Supplies
• Non-Specialty/Not Self Injectable
• Allergy Sera

*Please note: This is not meant to be an all-inclusive list of covered or excluded benefits, please contact Express Scripts customer service to verify specific coverage.

Appeals

For all claims other than direct claims:

In the event you receive an adverse benefit determination following a request for coverage of a prescription benefit claims, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to Express Scripts PO Box 66587, St. Louis, MO 63166-6587. A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to Express Scripts PO Box 66587, St. Louis, MO 63166-6587. You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request for an appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

You also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility.
You have the right to request an urgent appeal of an adverse benefit determination (including a deemed denial) if you request coverage of a claim that is urgent. You or your physician may call 800-753-2851 or send a written request to Express Scripts PO Box 66587, St. Louis MO 63166-6587, Attn: Urgent Appeals. In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding.

Definitions

Brand-name drug
A medication that is available only from its original manufacturer or from another manufacturer that has a licensing agreement to make the drug with the brand-name manufacturer. These medications are marketed under a recognized brand name. A brand-name drug may have a generic equivalent once the manufacturer is required to allow other manufacturers the opportunity to make the medication.

Co-payment/Co-insurance
A portion of the total cost of the claim that must be paid by the member.

Direct Claim
A reimbursement process whereby the member pays 100% of the prescription drug cost at the time of purchase and then submits a paper claim for reimbursement.

Federal Legend Drugs
A drug that requires a prescription; these drugs can be identified by the presence of “Federal Legend” on the label.

Formulary
A list of commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings. An independent Pharmacy and Therapeutics committee updates this list regularly based on continuous evaluation of medications. You can contact Express Scripts Member Services at 1-877-476-9275 to determine if the brand-name drug you are taking is on the formulary. You can also locate this information at www.express-scripts.com. If a drug you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist. Using drugs on the formulary will keep your costs lower.

Generic Drug
Medication that is therapeutically equivalent to a brand medication, but manufactured at a lower cost. The Food and Drug Administration (FDA) requires generic medications to meet the same standards as Multi Source (brand) medications.

In-Network Retail Claims
Claims processed by pharmacies that are included in the member’s pharmacy network.

Maintenance Medication
Medications prescribed for long-term use, (e.g., the medication taken daily by high-blood pressure sufferers or diabetics).

Multi Source (Brand) Drug
Medication that may have an FDA generic equivalent substitute available.

Network Pharmacy
A retail pharmacy that has an agreement currently in effect with Express for this Plan to dispense Prescription Drugs to
members.

Non-Preferred Brand Name Drug
Drugs which are not recommended based on their relative (to other available products) poor performance in efficacy, safety or cost. A non-preferred drug will be dispensed but higher co-pay will be paid.

Out-Of-Network Claims
Claims processed by pharmacies that do not participate in the Plan’s pharmacy network.

Out-of-Network Pharmacy
A retail pharmacy that does not currently have an agreement with Express Scripts for this Plan.

Over the Counter (OTC)/equivalent list
A list of products that is available both over the counter and as prescription items in exactly the same dosage strength and dosage form.

Prior Authorization
Some medications may not be covered unless you receive approval through a prior authorization coverage review.

Step Therapy
A Plan rule that requires a member to first try one or more specified drugs to treat a particular medical condition before the Plan will cover another (usually more expensive) drug that the member’s doctor may have prescribed.