CIGNA HEALTHCARE OF ARIZONA, INC.

GROUP SERVICE AGREEMENT

Your Guide to Your Plan's Benefits

[Employer Name]

[Employee Name]
[Employee Address Line 1]
[Employee Address Line 2]
[Employee Address City, State ZIP]

NOTICE

Discrimination is Against the Law

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

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with Cigna, such as qualified sign language interpreters and 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 and information written in other languages.

If you need these services, contact Customer Service/Member Services at the toll-free phone number shown on your ID card, and ask an 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, Executive Office of Complaints, P.O. Box 188016, Chattanooga, TN37422.

If you need assistance filing a written grievance, please call the toll-free phone shown on 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; or by phone at 1-800-368-1019, 800-537-7697(TDD).

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

NOTICE

[Continuity of Care]

[In certain circumstances, if you are receiving continued care from a network provider and that provider's network status changes to out-of-network, you may be eligible to continue to receive care from the provider at the Participating Provider cost-sharing amount for up to 90 days from the date you are notified of your provider's termination. A continuing care patient is an individual who is: undergoing a course of treatment for a serious and complex condition from the provider or facility; pregnant and undergoing treatment for the pregnancy from the provider or facility; undergoing a course of institutional or inpatient care from the provider or facility; scheduled to undergo non-elective surgery, including receipt of post-operative care with respect to such a surgery; or determined to be terminally ill and is receiving treatment for such illness from the provider or facility. If applicable, you will be notified of your continuity of care options.]

[Provider Directories and Provider Networks]

[A list of network providers is available to you, without charge, by visiting www.my.cigna.com or calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as generic practice, affiliated or contracted with Cigna Healthcare or an organization contracting on its behalf.

Provider directory content is verified and updated, and processes are established for responding to provider network status inquiries, in accordance with applicable requirements of the federal No Surprises Act.

[A list of network pharmacies is available to you, without charge, by visiting www.my.cigna.com or calling the phone number on your ID card. The network consists of pharmacies affiliated or contracted with Cigna Healthplan or an organization contracting on its behalf.]

If you rely on a provider's network status in the provider directory or by contacting Cigna Healthcare at www.my.cigna.com or phone number on your ID card to receive covered services from that provider, and that network status is incorrect, then an in-network cost-share must be applied to the covered service as if the service were provided by a Participating Provider.]

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in Our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making Referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, access the website or call the phone number on your ID card.

Selection of a Primary Care Provider

Your plan may require or allow the designation of a Primary Care Provider. You have the right to designate any Primary Care Provider who participates in the network and who is available to accept You or Your family Members. If Your plan requires designation of a Primary Care Provider, Cigna may designate one for You until You make this designation. [For children, you may designate a pediatrician as the primary care provider.] For information on how to select a Primary Care Provider, and for a list of the participating Primary Care Providers, access the website or call the phone number on your ID card.

[Your Rights and Protections Against Surprise Medical Bills]

[When you get emergency care or are treated by an out-of-network provider at a network hospital or ambulatory surgical center, you are protected from balance billing. In these situations, you should not be charged more than your plan's copayments, coinsurance, and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or deductible. You may have added costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**". This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care – such as when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

- **Emergency services** – If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as a copayments, coinsurance, and deductibles). You cannot be balanced billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Certain non-emergency services at an in-network hospital or ambulatory surgical center** – When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balanced billed.

  If you get other types of services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you have these protections:

- You are only responsible for paying your share of the cost (such as copayments, coinsurance, and deductibles that you would pay if the provider were in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval in advance for services (also known as prior authorization).
  - Cover emergency services provided by out-of-network providers.
  - Base what you owe the provider or facility (cost sharing) on what it would pay an in-network provider or facility and show that amount in your Explanation of Benefits (EOB).
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you have been wrongly billed, contact Cigna Healthcare at the phone number on your ID card. You can also contact No Surprises Help Desk at [1-800-985-3059] or **[www.cms.gov/nosurprises] f**or more information about your rights under federal law.]]

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SECTION I. DEFINITIONS OF TERMS USED IN THIS GROUP SERVICE AGREEMENT

The following definitions will help You in understanding the terms that are used in this Group Service Agreement. As You are reading this Group Service Agreement You can refer back to this section**.** We have identified defined terms throughout the Agreement by capitalizing the first letter of the term**.**

Agreement

This Agreement, the Face Sheet, Benefit Summary, any optional Riders, any other attachments, Your Enrollment Application, and any subsequent written amendment or written modification to any part of the Agreement.

Anniversary Date of Agreement

The date written on the Face Sheet as the Agreement anniversary date.

Autism Spectrum Disorder

Means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association: Autistic Disorder, Asperger's Syndrome, Pervasive Developmental Disorder - Not Otherwise Specified.

Birthing Center

Means a licensed outpatient facility which provides accommodations for childbirth for low-risk maternity patients. The Birthing Center must meet all of the following criteria:

1. Has an organized staff of certified midwives, Physicians, and other trained personnel;
2. Has necessary medical equipment;
3. Has a written agreement to transfer to a hospital if necessary; and
4. Is in compliance with any applicable state or local regulations.

Cigna LifeSOURCE Transplant Network®

The Cigna LifeSOURCE Transplant Network® consists of designated in-network facilities that have met quality and cost criteria and have contracted with Cigna LifeSOURCE to provide transplant services as a participating provider in the Cigna LifeSOURCE Transplant Network®. In order to be considered a facility in the Cigna LifeSOURCE Transplant Network®, the facility must be a designated program for the specific type of transplant requested.

Coinsurance

The amount shown in Benefit Summary that You pay for certain covered Service and Supplies, which is a percentage of the Participating Providers negotiated charge. When the Participating Provider has contracted with the Healthplan to receive payment on a basis other than a fee-for-service amount, the charge may be calculated based on a Healthplan-determined percentage of actual billed charges.

Contract Year

The [one- twenty four] (1- 24)] -month[s] period beginning at 12:01 a.m. on the [first day of the initial term] or any renewal term and ending at 12:01 a.m. on the next anniversary of that date.

Copayment

The fixed dollar amount shown in Benefit Summary that You pay for certain covered Service and Supplies.

Creditable Coverage

Means coverage under any of the following:

- a self-funded or self-insured employee welfare benefit Policy that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001, et seq.);
- any group or individual health benefit Policy provided by a health insurance carrier or health maintenance organization;
- Part A or Part B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; Chapter 55 of Title 10, United States Code;
- a medical care program of the Indian Health Service or of a tribal organization;
- a state health benefits risk pool;
- a health Policy offered under Chapter 89 of Title 5, United States Code;
- a public health Policy as defined by federal regulations, including coverage established or maintained by a foreign country;
- a health benefit Policy under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e));
- Title XXI of the federal Social Security Act, or
- a state children's health insurance program.

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: a) walking, b) grooming, c) bathing, d) dressing, e) getting in or out of bed, (f) toileting, g) eating, h) preparing foods, or (i) taking medications that can be self-administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Days

Calendar days; not 24 hour periods unless otherwise expressly stated.

Dependent

An individual in the Subscriber's family who is enrolled as a Member under this Agreement. You must meet the Dependent eligibility requirements in "Section II. Enrollment and Effective Date of Coverage" to be eligible to enroll as a Dependent.

Emergency Services

Emergency Services are defined in "Section IV. Covered Services and Supplies."

Enrollment Application

The enrollment process that must be completed by an eligible individual in order for coverage to become effective.

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.

Face Sheet

The part of this Agreement that contains certain provisions affecting the relationship between the Healthplan and the Group. You can get a copy of the Face Sheet from the Group.

Group

The employer, labor union, trust, association, partnership, government entity, or other organization listed on the Face Sheet to this Agreement which enters into this Agreement and acts on behalf of Subscribers and Dependents who are enrolled as Members in the Healthplan.

Habilitative Services

Means those services and devices that help a person keep, learn or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Healthplan

The Cigna HealthCare Health Care Services Organization (HCSO) or commonly known as an HMO, which is organized under applicable law and is listed on the Face Sheet to this Agreement. Also referred to as "we", "us" or "our".

Healthplan Medical Director

A Physician charged by the Healthplan to assist in managing the quality of the medical care provided by Participating Providers in the Healthplan; or his designee.

Medical Services

Professional services of Physicians or Other Participating Health Professionals (except as limited or excluded by this Agreement), including medical, psychiatric, surgical, diagnostic, therapeutic, and preventive services.

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Healthplan Medical Director to be: required to diagnose or treat an illness, injury, disease or its symptoms; and

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration; and
- 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 and supplies. Where applicable, the Healthplan Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining the least intensive setting.

In determining whether health care services, supplies, or medications are Medically Necessary, the HealthPlan Medical Director relies on the clinical coverage policies maintained by the Healthplan or the Review Organization. Coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

Member

An individual meeting the eligibility criteria as a Subscriber or a Dependent who is enrolled for Healthplan coverage and for whom all required Prepayment Fees have been received by the Healthplan. Also referred to as "you" or "your".

Membership Unit

The unit of Members made up of the Subscriber and his Dependent(s).

Open Enrollment Period

The period of time established by the Healthplan and the Group as the time when Subscribers and their Dependents may enroll for coverage. The Open Enrollment Period occurs at least once every Contract Year.

Other Participating Health Care Facility

Other participating health care facilities are any facilities other than a Participating Hospital or hospice facility that is operated by or has an agreement to render services to Members. Examples of other participating health care facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals and sub-acute facilities.

Other Participating Health Professional

An individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver Medical Services and who has an agreement with the Healthplan to provide Covered Services and Supplies to Members. Other Participating Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

Participating Hospital

An institution licensed as an acute care hospital under the applicable state law, which has an agreement to provide hospital services to Members.

Participating Physician

A Primary Care Physician (PCP) or other Physician who has an agreement to provide Medical Services to Members.

Participating Provider

Participating Providers are Participating Hospitals, Participating Physicians, Other Participating Health Professionals, and other participating health care facilities. It also includes entities that have directly or indirectly contracted to arrange, through contracts with providers of health care services and/or supplies, for the provision of any covered Service and/or supply.

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).

Pediatric Dental Services

Means routine dental care examinations, preventive treatment and other services or treatment described in Section VI Pediatric Dental Benefits of this Agreement provided to a Member who is under age 19.

Pediatric Vision Services

Means vision care examinations, and other services or treatment described in the section, VII Pediatric Vision Benefits of this Agreement provided to a Member who is under age 19.

Physician

An individual who is qualified to practice medicine under the applicable state law (or a partnership or professional association of such people) and who is a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Plan Deductible

The Plan Deductible includes Covered Services and Supplies to be paid by you or your Dependent before benefits are payable under this plan. 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.

The **Individual Deductible** is the amount you are responsible for paying out-of-pocket, each Contract Year, for covered Services and Supplies (as identified in Benefit Summary.

You must meet your Individual Deductible before the Healthplan begins to pay the cost associated with your coverage.

However, when the amount paid by individuals in your Membership Unit to meet their Individual Deductibles equals the **Family Deductible** amount, all Members in the Membership Unit will be considered to have met their Individual Deductible for that Contract Year.

Prepayment Fee

The sum of money paid to the Healthplan by the Group in order for You to receive the Service and Supplies covered by this Agreement.

Primary Care Physician\Provider (PCP)

A Physician who practices general medicine, family medicine, internal medicine or pediatrics who, through an agreement with the Healthplan, provides basic health care services to You if You have chosen him as Your Primary Care Physician (PCP). Your Primary Care Physician (PCP) also arranges specialized services for You.

Primary Plan

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

Prior Authorization

The approval a Participating Provider must receive from the Healthplan Medical Director, prior to services being rendered, in order for certain Service and Supplies to be covered under this Agreement.

Qualified Medical Child Support Order

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 requirement above.

Referral

The approval You must receive from Your PCP in order for the services of a Participating Provider, other than the PCP, participating OB/GYN, chiropractic Physician to be covered.

Review Organization

The term Review Organization refers to an affiliate of the Healthplan or another entity to which the Healthplan 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.

Rider

An addendum to this Agreement between the Group and the Healthplan.

Schedule

The section of this Agreement that identifies applicable Copayments, Coinsurance, and maximums.

Service Area

The geographic area, as described in the Provider Directory applicable to Your plan, where the Healthplan is authorized to provide services.

Stabilize

Means, with respect to an emergency medical condition, to provide medical treatment necessary to assure, that no material deterioration of the condition individual is transferred from a facility, or with respect to a pregnant woman who is having contractions, to deliver.

Subscriber

An employee or a participant in the Group, who is enrolled as a Member under this Agreement. You must meet the requirements contained in "Section II Enrollment and Effective Date of Coverage" to be eligible to enroll as a Subscriber.

Total Out-of-Pocket Maximums

The total amount of Copayments, Deductible, and Coinsurance that an individual Member or Membership Unit must pay within a Contract Year, as identified in Benefit Summary and including Copayments in the Supplemental Prescription Drug Rider, and Coinsurance in this Agreement for Pediatric Dental Benefits. When the individual Member or Membership Unit has paid applicable Copayments, Deductible, and Coinsurance up to the Total Out-of-Pocket Maximum, that Member or Membership Unit will not be required to pay Copayments, Deductible, or Coinsurance for those Services and Supplies for the remainder of the Contract Year.

Urgent Care

Urgent Care is defined in "Section IV Covered Services and Supplies."

We/Us/Our

Cigna HealthCare of Arizona, Inc.

You/Your

The Subscriber and/or any of his or her Dependents.

SECTION II. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Who Can Enroll as a Member

To be eligible for covered Services and Supplies You must be enrolled as a Member. To be eligible to enroll as a Member You must meet either the Subscriber or Dependent eligibility criteria listed below. You must also meet and continue to meet the Group-specific enrollment and eligibility rules on the Face Sheet.

A. To be eligible to enroll as a Subscriber, You must:

1. be an employee of the Group or a participant in the Group; and
2. reside or work in the Service Area; and
3. meet and continue to meet these criteria.

B. To be eligible to enroll as a Dependent, You must:

1. be the Subscriber's lawful spouse and reside in the Service Area; or
2. be the natural child, step-child, or adopted child of the Subscriber or Subscriber's spouse; or the child for whom the Subscriber is the legal guardian, legally placed with the Subscriber for adoption, or supported pursuant to a court order imposed on the Subscriber (including a Qualified Medical Child Support Order), provided that the child:

   - has not yet reached age twenty-six (26);
   - or the child is twenty-six (26) or older and continuously incapable of self-sustaining support because of intellectual disabilities or a physical handicap which existed prior to attaining twenty-six (26) years of age You may be required to submit proof of the child's condition and dependence to Us within thirty-one (31) Days after the date the child ceases to qualify as a Dependent under subsection (i) and (ii) above. You may be required, from time to time during the next two (2) years, to provide proof of the continuation of the child's condition and dependence. Thereafter, You may be required to provide such proof only once a year.

   A Subscriber's grandchild is not eligible for coverage unless they meet the eligibility criteria for a Dependent.

   NOTE: A child eligible to enroll as a Dependent under this Agreement who resides outside of the Service Area, is entitled to receive, while outside the Service Area, only out-of-area emergency benefits under the "Emergency Services" provision of the "Services and Benefits" section.

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 a Subscriber.

Enrollment and Effective Date of Coverage

C. Enrollment during an Open Enrollment Period

If You meet the Subscriber or Dependent eligibility criteria, You may enroll as a Member during the Open Enrollment Period by submitting a completed Enrollment Application, together with any applicable fees, to the Group.

If enrolled during the Open Enrollment Period, Your effective date of coverage is the first day of the Contract Year.

D. Arizona State Continuation for groups with less than 20 employees

This continuation is only applicable when COBRA does not apply.

This continuation applies to covered employees, dependents and domestic partners.

This continuation is not available to any individual who is entitled to COBRA, Medicare, Medicaid, or coverage under another group health plan.

Continuation is available upon the occurrence of any of the following events as indicated which results in loss of coverage under the plan:

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

Special Provisions: Disabled Qualified Dependent:

If a qualified dependent is determined by the Social Security Administration to have a disability at the time of a qualifying event then the qualified dependent may be eligible to continue coverage for an additional eleven months if the qualified dependent provides the written determination of disability from the Social Security Administration to the employer within sixty days after the date of that determination and before the end of the eighteen month continuation period. The qualified dependent shall notify the employer within thirty days after the Social Security Administration determines that the qualified dependent no longer has a disability.

Notice of the right to elect continuation must be sent in writing by the employer to the individual within thirty days after the qualifying event.

A qualified individual must elect continuation of coverage under this state law within sixty days after the date of the notice and submit the first month premium to the employer within forty five days after the date of election to continue coverage.

A qualified individual may continue coverage for a maximum of 18 months after the date the continuation coverage begins. If a qualifying event occurs during the eighteen month continuation period, a qualified dependent may be eligible to continue coverage for an additional eighteen months

E. Special Enrollment

If, after the Open Enrollment Period, You experience a special enrollment event, You and Your eligible Dependent(s) may enroll within thirty-one (31) Days of the special enrollment event. To enroll, You must submit an Enrollment Application, together with any additional fees due, to the Group. If so enrolled, Your effective date of coverage will be the day on which You meet the eligibility criteria.

Special Enrollment Events:

- A Subscriber or Dependent loses his or her minimum essential coverage; or
- A Subscriber gains a Dependent by marriage, birth, adoption, or placement for adoption; or
- A Subscriber or Dependent loses employer-sponsored health plan coverage due to a reduction of work hours, or a voluntary or involuntary termination of employment for reasons other than misconduct; or
- A Dependent loses coverage under an employer-sponsored health plan due to divorce, legal separation; or his or her spouse, or parent becoming entitled to or enrolled in Medicare; or death of his or her spouse or parent; or
- A Dependent child loses his or her dependent child status.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.
If You do not enroll within the thirty-one (31) Days, Your next opportunity to enroll will be during the next Open Enrollment Period, unless you experience a subsequent special enrollment event.

A newborn child who is born while this Agreement is being paid for at single or two-party rate shall have coverage effective as of the date of birth, for the first 31 days. To continue coverage beyond the first 31 days the Subscriber must enroll the child prior to the birth or within thirty-one (31) days after the child's birth. The Subscriber must submit to the Healthplan through the Group an Enrollment Application and pay the additional Prepayment Fees due in order for coverage to be continued beyond the first 31 days. If these requirements are not met, the newborn child may be enrolled during the next designated Open Enrollment period.

A child who is legally adopted by or is placed with the Subscriber for adoption while this Agreement is being paid for at a single or two-party rate shall have coverage effective as of the date the child is placed with the Subscriber, for the first 31 days. To continue coverage beyond the first 31 days the Subscriber must enroll the child within thirty-one (31) days after the date of placement. The Subscriber must submit to the Healthplan through the Group an Enrollment Application and pay any additional Prepayment Fees due in order for coverage to be continued beyond the first 31 days. If these requirements are not met, the child may be enrolled during the next designated Open Enrollment period.

F. Full and Accurate Completion of Enrollment Application

Each Subscriber must fully and accurately complete the Enrollment Application. False, incomplete or misrepresented information provided in any Enrollment Application may, in the Healthplan's sole discretion, cause the coverage of the Subscriber and/or his Dependents to be null and void from its inception.

Hospitalization on the Effective Date of Coverage

If You are confined in a hospital on the effective date of Your coverage, You must notify Us of such a hospitalization within two (2) Days, or as soon as reasonably possible thereafter. When You become a Member of the Healthplan, You agree to permit the Healthplan to assume direct coordination of Your health care. We reserve the right to transfer You to the care of a Participating Provider and/or Participating Hospital if the Healthplan Medical Director, in consultation with Your attending Physician, determines that it is medically safe to do so.

We will not be obligated to pay for any medical or hospital expenses that are related to Your hospitalization following the first two (2) Days after Your coverage begins, if:

- You are hospitalized on the effective date of coverage and You fail to notify Us of this hospitalization within two (2) days, or as soon as reasonably possible; or
- You are hospitalized at a non-Participating Hospital or are under the care of a non-Participating provider and you refuse to permit Us to coordinate Your care, or be transferred to the care of a Participating Provider or Participating Hospital.

SECTION III. AGREEMENT PROVISIONS

Healthplan's Representations and Disclosures

1. The Healthplan is a for-profit Health Care Services Organization (HCSO) or commonly known as an HMO, which arranges for the provision of covered Service and Supplies through a network of Participating Providers. The list of Participating Providers is provided to all Members at enrollment without charge. If You would like another list of Participating Providers, please contact Member Services at the toll-free number found on Your Cigna HealthCare ID card or visit the Cigna HealthCare web site at mycigna.com

2. With the exception of any employed Physicians who work in a facility operated by the Healthplan (so-called "staff model" providers), the Participating Providers are independent contractors. They are not the agents or employees of the Healthplan and they are not under the control of the Healthplan or any Cigna company. All Participating Providers are required to exercise their independent medical judgment when providing care.

3. The Healthplan maintains all medical information concerning a Member as confidential in accordance with applicable laws and professional codes of ethics. A copy of the Healthplan's confidentiality policy is available upon request.

4. We do not restrict communication between Participating Providers and Members regarding treatment options.

5. Under federal law (the Patient Self-Determination Act), You may execute advance directives, such as living wills or a durable power of attorney for health care, which permit You to state Your wishes regarding Your health care should You become incapacitated.

6. Upon Your admission to a participating inpatient facility, a Participating Physician other than Your PCP may be asked to direct and oversee Your care for as long as You are in the inpatient facility. This Participating Physician is often referred to as an "inpatient manager" or "hospitalist."

7. The terms of this Agreement may be changed in the future, after 60 days advance notice has been given, either as a result of an amendment agreed upon by the Healthplan and Group or to comply with changes in law. The Group or the Healthplan may terminate this Agreement as specified in this Agreement. In addition, Group reserves the right to discontinue offering any plan of coverage.

Choosing a Primary Care Physician

When You enroll as a Member, You must choose a Primary Care Physician (PCP). Each covered Member of Your family also must choose a PCP. If You do not select a PCP, We will assign one for You. If Your PCP leaves the Cigna HealthCare network, You will be able to choose a new PCP. You may voluntarily change Your PCP for other reasons but not more than once in any calendar month. We reserve the right to determine the number of times during a Contract Year that You will be allowed to change Your PCP. If You select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following Your selection. If You select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example,

if You notify Us on June 10, the change will be effective on July 1. If You notify Us on June 15, the change will be effective on August 1.

Your choice of a PCP may affect the specialists and facilities from which You may receive services. Your choice of a specialist may be limited to specialists in Your PCP's medical group or network. Therefore, You may not have access to every specialist or Participating Provider in Your Service Area. Before You select a PCP, You should check to see if that PCP is associated with the specialist or facility You prefer to use. If the Referral is not possible, You should ask the specialist or facility about which PCPs can make Referrals to them, and then verify the information with the PCP before making Your selection.

Referrals to Specialists

You must obtain a Referral from Your PCP before visiting any provider other than Your PCP in order for the visit to be covered. The Referral authorizes the specific number of visits that You may make to a provider within a specified period of time. If You receive treatment from a provider other than Your PCP without a Referral from Your PCP, the treatment is not covered.

Exceptions to the Referral process

If You are a female Member, You may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in "Section IV Covered Services and Supplies," without a Referral from Your PCP.

If You are a member under age 19, You may visit a Network Dentist for Pediatric Dental Benefits or a Network Vision Provider for Pediatric Vision Benefits without a Referral from Your PCP.

You do not need a Referral from Your PCP for Emergency Services as defined in the "Section IV Covered Services and Supplies." In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or Your local emergency service, police or fire department for help. You do not need a Referral from Your PCP for Emergency Services, but You do need to call Your PCP as soon as possible for further assistance and advice on follow-up care.

In an emergency, You should seek immediate medical attention and then as soon as possible thereafter You need to call Your PCP for further assistance and advice on follow-up care.

In an Urgent Care situation a Referral is not required but You should, whenever possible, contact Your PCP for direction prior to receiving services

Direct Access for Mental Health and Substance Use Disorder Services

Members covered by this Agreement are allowed direct access to a licensed/certified Participating Provider for covered Mental Health and Substance Use Disorder Services. There is no requirement to obtain a referral from your Primary Care Physician for individual or group therapy visits to the Participating Provider of your choice for Mental Health and Substance Use Disorder Services.

Standing Referral to Specialist

You may apply for a standing Referral to a provider other than Your PCP when all of the following conditions apply:

1. You are a covered Member of the Healthplan;
2. You have a disease or condition that is life threatening, degenerative, chronic or disabling;
3. Your PCP in conjunction with network specialist determines that Your care requires another provider's expertise;
4. Your PCP determines that Your disease or condition will require ongoing medical care for an extended period of time;
5. The standing Referral is made by Your PCP to a network specialist who will be responsible for providing and coordinating Your specialty care; and
6. The network specialist is authorized by the Healthplan to provide the services under the standing Referral.

We may limit the number of visits and time period for which You may receive a standing Referral. If You receive a standing Referral or any other Referral from Your PCP, that Referral remains in effect even if the PCP leaves the Healthplan's network. If the treating specialist leaves the Healthplan's network or You cease to be a covered Member, the standing Referral expires.

Transition Care

There may be instances in which Your PCP becomes unaffiliated with the Healthplan's network of Participating Providers. In such cases, You will be notified and provided assistance in selecting a new PCP.

However, in special circumstances, You may be able to continue seeing Your doctor, even though he or she is no longer affiliated with the Healthplan. If you are a new Member, upon written request to the Healthplan, you may continue an active course of treatment with your current health care provider during a transitional period after the effective date of enrollment if both of the following apply:

- You have a life threatening disease or condition, in which case the transitional period will not be more than thirty (30) days after the effective date of enrollment;
- Entered the third trimester of pregnancy on the effective date of enrollment, in which case the transitional period includes the delivery and any care up to six weeks after the delivery that is related to the delivery

If You have been receiving care and a continued course of covered treatment is Medically Necessary, You may be eligible to receive "transitional care" from the non-Participating Provider for up to ninety (90) Days. You may also be eligible to receive transitional care if You are in Your second or third trimester of pregnancy. In this case, transitional care may continue through Your delivery and post-partum care. Such transitional care must be approved in advance by the Healthplan, and Your doctor must agree to accept Our reimbursement rate and to abide by the Healthplan's policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider no longer participating in the Healthplan's network will not be available, such as when the provider loses his license to practice or retires.

If You are a new Member whose health care provider is not a Member of the Healthplan's network and You (i) are receiving an on-going course of treatment for a life-threatening disease or condition, or a degenerative or disabling disease or condition, or (ii) have entered Your second or third trimester of pregnancy as of the effective date of Your enrollment, You may be eligible to receive continuity of care from that non-Participating Provider for a transitional period of up to ninety (90) Days, or the postpartum period directly related to the delivery of Your child. Such continuity of care must be approved in advance by the Healthplan, and Your doctor must agree to accept Our reimbursement rate and to abide by the Healthplan policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider no longer participating in the Healthplan's network will not be available, such as when the provider loses his/her license to practice or retires.

Continuity of Care on Policy Termination

The Policyholder must provide written notice to insureds, who are continuing care patients as defined in §2799A-3(b)(1) of the PHS Act, of the opportunity to elect continuity of care coverage when this policy is terminated, either by the Policyholder or by the Insurance Company. The Policyholder will provide promptly to the Insurance Company proof of that mailing and the date thereof.

Provider Compensation

We compensate Our Participating Providers in ways that are intended to emphasize preventive care, promote quality of care, and assure the most appropriate use of Medical Services. You can discuss with Your provider how he is compensated by Us. The methods We use to compensate Participating Providers are:

Discounted fee for service – payment for service is based on an agreed upon discounted amount for the services provided.

Capitation – Physicians, provider groups and Physician/hospital organizations are paid a fixed amount at regular intervals for each Member assigned to the Physician, provider group or Physician/hospital organization, whether or not services are provided. This payment covers Physician and/or, where applicable, hospital or other services covered under the benefit plan. Medical groups and Physician/hospital organizations may in turn compensate providers using a variety of methods.

Capitation offers health care providers a predictable income, encourages Physicians to keep people well through preventive care, eliminates the financial incentive to provide services that will not benefit the patient, and reduces paperwork.

Providers paid on a "capitated" basis may participate with Us in a risk sharing arrangement. They agree upon a target amount for the cost of certain health care services, and they share all or some of the amount by which actual costs are over target. Provider services are monitored for appropriate utilization, accessibility, quality and Member satisfaction.

We may also work with third parties who administer payments to Participating Providers. Under these arrangements, We pay the third party a fixed monthly amount for these services. Providers are compensated by the third party for services provided to Healthplan participants from the fixed amount. The compensation varies based on overall utilization.

Salary – Physicians and other providers who are employed to work in Our medical facilities are paid a salary. The compensation is based on a dollar amount, decided in advance each year, that is guaranteed regardless of the services provided. Physicians are eligible for any annual bonus based on quality of care, quality of service and appropriate use of Medical Services.

Incentives to Participating Providers

Cigna continuously develops programs to help you access quality, cost-effective health care. Some programs include Participating Providers receiving financial incentives from Cigna Healthplan for providing care to you in a way that meets or exceeds certain quality and/or cost-efficiency standards, when, in the Participating Provider's professional judgment, it is appropriate to do so within the applicable standard of care. For example, some Participating Providers could receive financial incentives for [prescribing lower-cost prescription drugs to manage certain conditions,] utilizing or referring you to alternative sites of care as determined by the plan rather than in a more expensive setting, or achieving particular outcomes for certain health conditions. Participating Providers may also receive purchasing discounts when purchasing certain prescription drugs from Cigna Healthplan affiliates. Such programs can help make you healthier, decrease your health care costs, or both. These programs are not intended to affect your access to the health care that you need. We encourage you to talk to your Participating Provider if you have questions about whether they receive financial incentives from Cigna Healthplan and whether those incentives apply to your care.

Per Diem – A specific amount is paid to a hospital per day for all health care received. The payment may vary by type of service and length of stay. Case Rate – A specific amount is paid for all the care received in the hospital for each standard service category as specified in Our contract with the provider (e.g., for a normal maternity delivery).

Network Exception

If you receive covered services from a non-Participating Provider either:

- Because there is no Participating Provider accessible or available that can provide You timely covered services, or
- For any reason We determine it is in Your best interests to receive care from a non-Participating Provider:

Coverage received through the non-Participating Provider shall be limited to covered services to which You would have been entitled under this Agreement, and You will be reimbursed for only the costs that You incur that You would not have incurred if You received the services in-network.

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.

Services may include, but are not limited to: professional-to-professional consultations, outreach to patients, care coordination, and other services intended to achieve improved health outcomes.

Member's Rights, Roles and Representations

You have the right to:

1. Medical treatment that is available when You need it and is handled in a way that respects Your privacy and dignity.
2. Get the information You need about Your health care plan, including information about services that are covered, services that are not covered, and any costs that You will be responsible for paying.
3. Have access to a current list of providers in Our network and have access to information about a particular provider's education, training and practice.
4. Select a Primary Care Physician (PCP) for Yourself and each covered Member of Your family, and to change Your PCP for any reason.
5. Have Your medical information kept confidential by Our employees and Your health care provider. Confidentiality laws and professional rules of behavior allow Us to release medical information only when it's required for Your care, required by law, necessary for the administration of Your plan or to support Our programs or operations that evaluate quality and service. We may also summarize information in reports that do not identify You or any other participants specifically.
6. Have Your health care provider give You information about Your medical condition and Your treatment options, regardless of benefit coverage or cost. You have the right to receive this information in terms You understand.
7. Learn about any care You receive. You should be asked for Your consent to all care unless there is an emergency and Your life and health are in serious danger.

8. Refuse medical care. If You refuse medical care, Your health care provider should tell You what might happen. We urge You to discuss Your concerns about care with Your PCP or another Participating Physician. Your doctor will give You advice, but You will always have the final decision.
9. Be heard. Our complaint-handling process is designed to hear and act on Your complaint or concern about Us and/or the quality of care You receive, provide a courteous, prompt response, and to guide You through Our appeals process if You do not agree with Our decision.
10. Make recommendations regarding Our policies on Member rights and responsibilities. If You have recommendations, please contact Member Services at the toll-free number on Your Cigna HealthCare ID card.

Your role is to:

1. Review and understand the information You receive about Your health care plan. Please call Cigna HealthCare Member Services when You have questions or concerns.
2. Understand how to obtain covered Service and Supplies that are provided under Your plan.
3. Show Your Cigna HealthCare ID card before You receive care.
4. Schedule a new patient appointment with any new Cigna HealthCare PCP; build a comfortable relationship with Your doctor; ask questions about things You don't understand; and follow Your doctor's advice. You should also understand that Your condition may not improve and may even get worse if You don't follow Your doctor's advice.
5. Understand Your health condition and work with Your doctor to develop treatment goals that You both agree upon, to the extent that this is possible.
6. Provide honest, complete information to the providers caring for You.
7. Know what medicine You take, why, and how to take it.
8. Pay all Copayments for which You are responsible at the time the service is received.
9. Keep scheduled appointments and notify the doctor's office ahead of time if You are going to be late or miss an appointment.
10. Pay all charges for missed appointments and for services that are not covered by Your plan.
11. Voice Your opinions, concerns or complaints to Cigna HealthCare Member Services and/or Your provider.
12. Notify Your employer as soon as possible about any changes in family size, address, phone number or membership status.

You represent that:

1. The information provided to Us and the Group in the Enrollment Application is complete and accurate.

2. By enrolling in the Healthplan, You accept and agree to all terms and conditions of this Agreement.

3. By presenting Your Cigna HealthCare ID card and receiving treatment and services from Our Participating Providers, You authorize the following to the extent allowed by law:

   a. any provider to provide Us with information and copies of any records related to Your condition and treatment;

   b. any person or entity having confidential information to provide any such confidential information upon request to Us, any Participating Provider, and any other provider or entity performing a service, for the purpose of administration of the plan, the performance of any Healthplan program or operations, or assessing or facilitating quality and accessibility of health care Service and Supplies;

   c. Us to disclose confidential information to any persons, company or entity to the extent We determine that such disclosure is necessary or appropriate for the administration of the plan, the performance of the Healthplan programs or operations, assessing or facilitating quality and accessibility of healthcare Service and Supplies, or reporting to third parties involved in plan administration; and

   d. that payment be made under Part B of Medicare to Us for medical and other services furnished to You for which We pay or have paid, if applicable.

   This authorization will remain in effect until You send Us a written notice revoking it or for such shorter period as required by law. Until revoked, We and other parties may rely upon this authorization.

   With respect to Members, confidential information includes any medical, dental, mental health, substance use disorder, communicable disease, AIDS and HIV related information and disability or employment related information.

4. You will not seek treatment as a Cigna HealthCare Member once Your eligibility for coverage under this Agreement has ceased

When You Have a Complaint or Appeal

When You Have a Complaint or an Appeal Start with Customer Service We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of Our customer service representatives. Please call Us at the customer service toll-free number that appears on your ID card, explanation of benefits or claim form. We will do Our best to resolve the matter on your initial contact. If We need more time to review or investigate your concern, We will get back to you as soon as possible, but in any case, within 30 days. If you are not satisfied with the results of a coverage decision, you can start the appeals procedure. We want you to be completely satisfied with the care you receive. That is why We have established a process for addressing your concerns and solving your problems. The Appeals Process Information Packet (Appeal Packet) describes the process by which Members may obtain information and submit concerns regarding service, benefits, and coverage. For more information, see the Appeals Process Information Packet (Appeal Packet). We will provide You with a copy of the Appeal Packet in Your Cigna Plan Notice when You first enroll, and within 5 business days after We receive your request for an appeal. When Your insurance coverage is renewed, We must also send You a separate statement to remind You that you can request another copy of this packet, which is included in Your renewal letter. We will also send a copy of this packet to You or Your treating Provider at any time upon request. Just call Customer Service at the toll-free number that appears on the back of your ID card.

SECTION IV. COVERED SERVICES AND SUPPLIES

The Covered Services and Supplies available to Members under this plan are described below. Any applicable Copayments and other limits are identified in Benefit Summary.

Unless otherwise authorized in writing by the Healthplan Medical Director, covered Service and Supplies are available to Members only if:

- They are Medically Necessary and not specifically excluded in this Section or in Section V.
- Provided by Your Primary Care Physician (PCP) or if Your PCP has given You a Referral, by another Participating Provider. However, "Emergency Services", do not require a Referral from Your PCP and do not have to be provided by Participating Providers. Also, You do not need a Referral from Your PCP for "Obstetrical and Gynecological Services", "Urgent Care", "Pediatric Vision" services, and "Pediatric Dental" services.
- Prior Authorization is obtained from the Healthplan Medical Director by the Participating Provider, for those services that require Prior Authorization. Services that require Prior Authorization include, but are not limited to, inpatient hospital services, inpatient services at any other participating healthcare facility, residential treatment, outpatient facility services, partial hospitalization, intensive outpatient programs, advanced radiological imaging, non-emergency ambulance, Specialty Medication, and Transplant Services. Prior authorization for non-emergency ambulance services may be obtained from a Participating Provider that is treating the Member.

  Failure to obtain Prior Authorization prior to an elective admission to a hospital or elective outpatient procedures may result in a penalty or denial of payment to the provider for the services rendered. Prior Authorization must be obtained by the Participating Provider by calling the number on the back of your ID card.

Physician Services

All diagnostic and treatment services provided by Participating Physicians and Other Participating Health Professionals, including office visits, periodic health assessments, well-child care and routine immunizations provided in accordance with accepted medical practices, hospital care, consultation, and surgical procedures.

Inpatient Hospital Services

Inpatient hospital services for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in an Other Participating Health Care Facility. Inpatient hospital services include semi-private room and board; care and services in an intensive care unit; drugs, medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; laboratory and radiology services and other diagnostic and therapeutic services; anesthesia and associated services; inhalation therapy; radiation therapy; admit kit; and other services which are customarily provided in acute care hospitals. Inpatient Hospital services also include Birthing Center.

Inpatient hospital services rendered by a non-Participating Provider: Charges for services furnished by a non-Participating Provider in a Participating facility while you are receiving Participating Provider services at that Participating facility are payable at the cost-sharing level applicable to Participating Providers. The allowable amount used to determine the plan's benefit payment for the non-Participating Provider services is the amount agreed to by the non-Participating Provider and the Healthplan, or as required by applicable state or Federal law. You are responsible for applicable cost-sharing amounts (any Deductible, Copayment [or Coinsurance]). You are not responsible for any charges that may be made in excess of the allowable amount. If the non-Participating Provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Member Services at the phone number on your ID card.

Outpatient Facility Services

Services provided on an outpatient basis, including: diagnostic and/or treatment services; administered drugs, medications, fluids, biologicals, blood and blood products; inhalation therapy; and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, and recovery room services.

Outpatient facility services rendered by a non-Participating Provider: Charges for services furnished by a non-Participating Provider in a Participating facility while you are receiving Participating Provider services at that Participating facility are payable at the cost-sharing level applicable to Participating Providers. The allowable amount used to determine the plan's benefit payment for the non-Participating Provider services is the amount agreed to by the non-Participating Provider and the Healthplan, or as required by applicable state or Federal law. You are responsible for applicable cost-sharing amounts (any Deductible, Copayment or Coinsurance). You are not responsible for any charges that may be made in excess of the allowable amount. If the non-Participating Provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Member Services at the phone number on your ID card.

Emergency Services and Urgent Care

Emergency Services Both In and Out of the Service Area. In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or Your local emergency service, police or fire department for help. You do not need a Referral for Emergency Services, but You do need to call Your PCP [or the Cigna HealthCare 24-Hour Health Information Line SM] as soon as possible for further assistance and advice on follow-up care. If You require specialty care or a hospital admission, Your PCP [or the Cigna HealthCare 24-Hour Health Information Line SM] will coordinate it and handle the necessary authorizations for care or hospitalization. Participating Providers are on call twenty-four (24) hours a day, seven (7) days a week, to assist You when You need Emergency Services.

If You receive Emergency Services outside the Service Area, You must notify Us as soon as reasonably possible. We may arrange to have You transferred to a Participating Provider for continuing or follow-up care if it is determined to be medically safe to do so.

Emergency medical condition means a medical or behavioral condition, including a mental health condition or substance use disorder, manifesting 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; or with respect to a pregnant woman having contractions, that there is inadequate time to effect a safe transfer to another hospital for delivery, or to Stabilize the medical condition of a pregnant woman; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or a behavioral health condition that places health of insured or others in serious jeopardy.

Emergency services means, with respect to an emergency medical condition a medical screening examination that is within the capability of the emergency department of a hospital or independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital or emergency department, as are required to Stabilize the patient. After the patient is Stabilized, services rendered by an out-of-network provider, Hospital or facility (regardless of the Hospital department that provides the services) as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are provided.

However, such post-Stabilization services are not considered Emergency Services if the attending provider determines the patient is able to travel using non-medical or non-emergency transportation to an available in-network location within reasonable travel distance and applicable state and federal notice and consent requirements are met.]

Urgent Care Inside the Service Area. For Urgent Care inside the Service Area, You must take all reasonable steps to contact Your PCP for direction and You must receive care from a Participating Provider, unless otherwise authorized by Your PCP or the Healthplan.

Urgent Care Outside the Service Area. In the event You need Urgent Care while outside the Service Area, You should, whenever possible, contact [the Cigna HealthCare 24 Hour Health Information Line ^{SM} or] Your PCP for direction and authorization prior to receiving services.

Urgent Care is defined as medical, surgical, hospital and related health care services and testing which are not Emergency Services, but which are determined by the Healthplan Medical Director 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 are 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 You should not travel due to any medical condition.

Continuing or Follow-up Treatment. Continuing or follow-up treatment, whether in or out of the Service Area, is not covered unless it is provided or arranged for by Your PCP, a Participating Physician or upon Prior Authorization of the Healthplan Medical Director.

Notification, Proof of a Claim, and Payment. Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and authorization by the Healthplan Medical Director. Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than within forty-eight (48) hours of admission. This requirement shall not cause denial of an otherwise valid claim if You could not reasonably comply, provided that notification is given to Us as soon as reasonably possible. If You receive Emergency Services or Urgent Care from non-Participating Providers, You must submit a claim to Us no later than sixty (60) days after the first service is provided. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if You could not reasonably comply, provided You submit the claim and the itemized statement to Us as soon as reasonably possible. Coverage for Emergency Services and Urgent Care received through non-Participating Providers shall be limited to covered services to which You would have been entitled under this Agreement, and You will be reimbursed for only the costs that You incur that You would not have incurred if You received the services in-network.

Emergency Services rendered by a non-Participating Provider. Emergency Services are covered at the cost-sharing level applicable to Participating Providers.

[The allowable amount used to determine the plan's benefit payment for covered Emergency Services rendered in a non-Participating Hospital or by a non-Participating Provider in a Participating Hospital, is the amount agreed to by the non-Participating provider and the Healthplan, or as required by applicable state of Federal law.]

The allowable amount used to determine the plan's benefit payment when Emergency Services result in a non-Participating Hospital admission is the median amount negotiated with Participating facilities.
The amount We pay an Out-of-Network Provider for Emergency Services will be the amount We have negotiated with the Out-of-Network Provider for the Emergency Service or as required by applicable state or Federal law.

You are responsible for applicable In-Network Cost Share amounts (any Deductible, Copay or Coinsurance). The Member is not responsible for any charges that may be made in excess of the Allowable Amount. If the Out-of-Network Provider bills you for an amount higher than the amount You owe as indicated on the Explanation of Benefits (EOB), contact Member Services at the phone number on your ID card.

Advanced Imaging

Benefits are covered for:

Outpatient and ambulatory magnetic resonance imaging (MRI/MRA), PET Scans, ECT, BEAM (Brain Electrical Activity Mapping), and CAT/CT imagery.

Ambulance Service

Ambulance services to an appropriate provider or facility. Prior authorization for non-emergency ambulance services may be obtained from a Participating Provider that is treating the Member.

Coverage for air ambulance related to an Emergency Medical Condition or air ambulance related to non-Emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:

- The point of pick-up is inaccessible by land vehicle; or
- Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

Air ambulance services rendered by a non-Participating Provider: Covered air ambulance services are payable at the cost-sharing level applicable to Participating Providers. The allowable amount used to determine the plan's benefit payment for covered air ambulance services rendered by a non-Participating Provider is the amount agreed to by the non-Participating Provider and the Healthplan, or as required by applicable state or Federal law. You are responsible for applicable cost-sharing amounts (any Deductible, Copayment or Coinsurance). You are not responsible for any charges that may be made in excess of the allowable amount. If the non-Participating Provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Member Services at the phone number on your ID card.

Important Notice on Ambulance Services for Mental Health and Substance Use Disorders
Covered medical services received for Ambulance charges provided for Mental Health or Substance Use Disorders will be payable according to the benefits outlined in the Emergency/Urgent and Ambulance Services section of your plan's Schedule of Benefits.

Autism Spectrum Disorders

Benefits are covered for:

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

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

1) a Physician licensed to practice medicine or
2) a certified, registered, or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a Physician licensed to practice medicine:
   (a) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
   (b) Psychological care, meaning direct or consultative services provided by a licensed psychologist.
   (c) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.

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

3) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:

(a) self-care and feeding,

(b) pragmatic, receptive, and expressive language,

(c) cognitive functioning,

(d) applied behavior analysis, intervention, and modification,

(e) motor planning, and

(f) sensory processing.

Upon request from Cigna, a provider of treatment for Autism Spectrum Disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is Medically Necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, Cigna may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

Bariatric Services

Benefits for the following bariatric surgery procedures are covered:

- open roux-en-y gastric bypass (RYGBP),
- laparoscopic roux-en-y gastric bypass (RYGBP),
- laparoscopic adjustable gastric banding (LAGB),
- open biliopancreatic diversion with duodenal switch (BPD/DS), and
- laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS)
- laparoscopic sleeve gastrectomy

Only if all the following criteria are met:

- The patient must have a body-mass index (BMI) ≥35, and
- have at least one co-morbidity related to obesity, and
- had previously unsuccessful with medical treatment for obesity.
- The following medical information must be documented in the patient's medical record:

  Active participation within the last two years in one Physician–supervised, weight-management program for a minimum of six months without significant gaps. The weight-management program must include monthly documentation of all of the following components:
  - Weight
  - Current dietary program
  - Physical activity (e.g., exercise program)
- In addition, the procedure must be performed at an approved Center of Excellence facility that is credentialed by Cigna to perform bariatric surgery.

- The Member must be 18 years or older, or have reached full expected skeletal growth.

If treatment was directly paid or covered by another plan, Medically Necessary adjustments will be covered.

The following bariatric procedures are not covered:

- Open vertical banded gastroplasty;
- Laparoscopic vertical banded gastroplasty;
- Open sleeve gastrectomy;
- Open adjustable gastric banding.

Biomarker Testing

Biomarker testing is covered for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of an Insured Person's disease or condition to guide treatment decisions when the test provides clinical utility as demonstrated by medical and scientific evidence, including any of the following:

- Labeled indications for tests that are approved or cleared by the FDA or indicated tests for a drug approved by the FDA;
- CMS national coverage determinations or Medicare administrative contractor local coverage determinations;
- Nationally recognized clinical practice guidelines and consensus statements.

Biomarker:

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

Biomarker Testing:

- Means the analysis of patient's tissue, blood, or other biospecimen for the presence of a biomarker
- Includes single-analyte tests, multiplex panel tests, and whole genome sequencing.

Breast Reconstruction and Breast Prostheses

Following a mastectomy, the following Services and Supplies are covered:

- surgical services for reconstruction of the breast on which the mastectomy was performed;
- surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
- post-operative breast prostheses; and
- mastectomy bras/camisoles and prosthetics, limited to the lowest cost alternative available that meets prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Clinical Trials

Coverage shall be provided for Medically Necessary covered patient costs that are directly associated with an approved clinical trial (Phases I-IV) for prevention, detection and treatment of cancer or other life-threatening diseases or conditions for a covered person who meets the following requirements.

1. Is eligible to participate in an approved clinical trial according to the trial protocol with respect to the prevention, detection or treatment of cancer or other life-threatening disease or condition; and
2. Either:
    - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such a trial would be appropriate based upon the individual meeting the conditions described in Paragraph (1); or
    - the covered person provides medical and scientific information establishing that his participation in such a trial would be appropriate based on the individual meeting the conditions described in Paragraph (1).

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

An approved clinical trial must meet one of the following requirements:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials; or.
- be conducted under an investigational new drug application reviewed by the Food and Drug administration; or
- involve a drug trial that is exempt from having such an investigational new drug application; or
- be approved by a panel of qualified recognized experts in clinical research within academic health institutions as part of a scientific study of a new therapy or intervention that is being conducted at an institution that is for the treatment, palliation or prevention of cancer in humans and in which the scientific study includes all of the following: (a) specific goals; (b) a rationale and background for the study; (c) criteria for patient selection; (d) specific directions for administering the therapy and monitoring patients; (e) definition of quantitative measures for determining treatment response; (f) methods for documenting and treating adverse reactions; (g) have been reviewed and approved by an institutional review board of an institution; and (h) the personnel providing the treatment or conducting the study at an institution agree to accept reimbursement as payment in full from the Healthplan at the rates that are established by the Healthplan and that are not more than the level of reimbursement applicable to other similar services provided by the health care providers in the Healthplan's network.

For the purposes of this specific covered Service and Benefit these terms shall have the following meaning:

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

- "**Patient Cost**" – means any fee or expense that is covered under the Evidence of Coverage and that is for a service or treatment that would be required if the patient were receiving usual and customary care, including the following:
    - services typically provided absent a clinical trial;
    - 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.

    Patient Cost does not include the cost of
    - the investigational item, or device;
    - 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;
    - non-health services that might be required for a person to receive treatment or intervention; or
    - services not covered under the Member's contract.

    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.
    - [The Qualified Individual's plan provides coverage for out of network services.]]

[Convenience Care Clinics]

[Convenience Care Clinics are staffed by nurse practitioners and physician assistants and offer customers convenient, professional walk-in care for common ailments and routine services. Convenience Care Clinics have extended hours and are located in or near easy-to-access, popular locations (pharmacies, grocery and free-standing locations) with or without appointment.]

Chiropractic Care Services

Diagnostic and treatment services utilized in an office setting by participating chiropractic or osteopathic 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 participating chiropractic physicians; You do not need a Referral from Your PCP.

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 designed to acquire levels of function that had not been previously achieved prior to the injury or illness.
- Services are not covered when they are considered custodial, training, educational or developmental in nature.

- Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living after an illness or injury.

The following are specifically excluded from chiropractic care services:

- Services of a chiropractic or osteopathic physician 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 reoccurrence or to maintain the patient's current status;
- Vitamin therapy; and
- Massage therapy in the absence of other modalities.

Compression Garments

Compression garments for treatment of lymphedema are covered, limited to one set upon diagnosis.

Up to four (4) replacements per calendar year are also covered when determined to be Medically Necessary by the Healthplan, and the compression stocking cannot be repaired, or when require due to a change in the member's physical condition.

Cosmetic Surgery

Cosmetic Surgery is covered for reconstructive surgery that constitutes necessary care and treatment of medically diagnosed services required for the prompt repair of accidental injury. Congenital defects and birth abnormalities are covered for eligible Dependent children. Non-life threatening complications of a non-covered cosmetic surgery are not covered. This includes, but is not limited to, subsequent surgery for reversal, revision or repair related to the procedure.

Dental Confinement/Anesthesia

This Agreement provides benefits for dental care for a fractured jaw or an accidental Injury to teeth, subject to the following:

With respect to dental confinement/anesthesia, facility and anesthesia services for hospitalization in connection with dental or oral surgery will be covered, provided that the confinement has been Pre-Certified because of a hazardous medical condition. Such conditions include heart problems, diabetes, hemophilia, dental extractions due to cancer related conditions, and the probability of allergic reaction (or any other condition that could increase the danger of anesthesia). All facility services must be provided by a contracted network provider.

Benefits are payable for general anesthesia/radiation therapy and associated facility charges for dental procedures rendered in a Participating Hospital or Freestanding Outpatient Surgical Facility for:

- an Insured Person who is a child;
- an Insured Person at any age who is developmentally disabled; or
- an Insured Person whose health is compromised and general anesthesia is Medically Necessary.

Diabetic Service and Supplies

Coverage will be provided for diabetic services, including dialysis and the following medically appropriate supplies, devices, and appliances prescribed by a health care provider for the treatment of diabetes:

1. Podiatric/ appliances for prevention of complications associated with diabetes; foot orthotic devices and inserts (therapeutic shoes: including Depth shoes or Custom Molded shoes.) Custom molded shoes will only be covered when the member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and *any* of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of preulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation. Definitions of Depth Shoes and Custom-Molded Shoes are as follows:
    - Depth Shoes shall mean the shoe has a full length, heel-to -toe filler that, when removed, provides a minimum of 3/16th inch of additional depth used to accommodate custom-molded or customized inserts; are made of leather or other suitable material of equal quality; have some sort of shoe closure; and are available in full and half sizes with a minimum of three widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent.
    - Custom-Molded Shoes shall mean constructed over a positive model of the member's foot; made from leather or other suitable material of equal quality; have removable inserts that can be altered or replaced as the member's condition warrants; and have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.

2. Any other device, medication, equipment or supply for which coverage is required under Medicare guidelines pertaining to diabetes management; and
    - Charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following: Medically appropriate visits when diabetes is diagnosed;
    - Visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
    - Visits when reeducation or refresher training is prescribed by the Physician; and
    - Medical nutrition therapy (education) related to diabetes management.

Eosinophilic Gastrointestinal Disorder

Amino acid-based formula that is ordered by a Physician or a registered nurse practitioner if;

1) You have been diagnosed with an Eosinophilic Gastrointestinal Disorder;
2) You are under continuous supervision of a Physician;
3) There is a risk of a mental or physical impairment without the use of the formula.

Gene Therapy

Charges for gene therapy products and services directly related to their administration are covered when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. The Healthplan determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when approved by the Healthplan Medical Director and received at a facility that is designated by the Healthplan to provide the specific gene therapy service. [Gene therapy products and their administration at other participating facilities are not covered.]

[Gene Therapy – Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy, and when the gene therapy products and services directly related to their administration are received at a facility designated by the Healthplan for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the 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.]

Durable Medical Equipment

Purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Participating Physician and provided by a vendor approved by the Healthplan. Coverage for repair, replacement or duplicate equipment is provided only when approved as Medically Necessary by the Healthplan Medical Director. The determination to either purchase or rent equipment expected to cost $1,000 or more will be made by the Healthplan Medical Director. All maintenance and repairs that result from a Member's misuse are the Member's responsibility.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serves a therapeutic purpose with respect to a particular Illness or Injury, as certified in writing by the attending medical provider; generally are not useful in the absence of illness or injury; are appropriate for use in the home; and is of a truly durable nature.. Such equipment includes, but is not limited to, crutches, hospital beds, ventilators, insulin pumps, wheel chairs, respirators, and dialysis machines. Durable Medical Equipment items that are not covered, include but are not limited to those that are listed below.

Unless covered in connection with the services described in the "Inpatient Services at Other Participating Health Care Facilities" or "Home Health Services" provisions, the following are specifically excluded:

- Hygienic or self-help items or equipment;
- Items or equipment 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 and humidifiers.
- Institutional equipment, such as air fluidized beds and diathermy machines;
- Elastic stockings;
- Wigs, except as provided in the "External Prosthetic Appliances and Devices" provisions of the "Covered Service and Supplies" section of the Agreement;
- Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, 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 lifts, ramps, railings, and grab bars; and
- Hearing aid batteries (except those for cochlear implants) and chargers.

External Prosthetic Appliances and Devices

The initial purchase and fitting of external prosthetic appliances and devices that are ordered by a Participating Physician, available only by prescription and are necessary for the alleviation or correction of illness, injury or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the Healthplan Medical Director.

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

Replacement of external prosthetic appliances is covered only if necessitated by normal anatomical growth or as a result of wear and tear.

Wigs and hair pieces are covered verifying diagnosis of alopecia as a result of chemotherapy, radiation therapy, second or third degree burns. Coverage is limited to one per year.

Prostheses/Prosthetic Appliances and Devices

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

- Basic limb prostheses (artificial arms and legs);
- Terminal devices such as hands or hooks; and
- Speech prostheses.

Orthoses and orthotic devices

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

- Non-foot orthoses – only the following non-foot orthoses are covered:
  a. Rigid and semi-rigid custom fabricated orthoses;
  b. Semi-rigid pre-fabricated and flexible orthoses; and
  c. Rigid pre-fabricated orthoses, including preparation, fitting and basic additions, such as bars and joints.

- Custom foot orthotics – custom foot orthoses are only covered as follows:
  a. For Members with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  b. When the foot orthosis is an integral part of a leg brace, and it is necessary for the proper functioning of the brace;
  c. When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of illness, injury, or congenital defect; and
  d. For Members with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot, and there is reasonable expectation of improvement.
  e. The following are specifically excluded orthoses & orthotic devices, unless provided in the Diabetic Services and Supplies Section:
     - Prefabricated foot orthoses;
     - Cranial banding/cranial orthoses/other similar devices are excluded, except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
     - Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
     - Orthoses primarily used for cosmetic rather than functional reasons; and
     - Orthoses primarily for improved athletic performance or sports participation.

Braces

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

Splints

A splint is defined as an appliance for preventing movement of joints or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

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

  Coverage for replacement is limited as follows:
  - No more than once every 24 months for Members 19 years of age and older;
  - No more than once every 12 months for Members 18 years of age and under; and
  - Replacement due to a surgical alteration or revision of the site. The following are specifically excluded external prosthetic appliances and devices:
    - External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
    - Myoelectric prostheses peripheral nerve stimulators.

Family Planning Services (Contraception and Voluntary Sterilization)

Family planning services including: medical history; physical examination; related laboratory tests; medical supervision in accordance with generally accepted medical practice; other Medical Services; information and counseling on contraception; implanted/injected contraceptives; and, after appropriate counseling, Medical Services connected with surgical therapies (vasectomy or tubal ligation).

At least one form of contraception is covered under each of the following categories identified by the FDA:

- Sterilization for women;
- Surgical sterilization via implant for women;
- Implantable rods;
- Copper intrauterine devices;
- Intrauterine devices with progestin (all durations and doses);
- The shot or injection.

Additional information is available at https://www.fda.gov/consumers/free-publications-women/birth-control-chart for members.

Please also see Your Prescription Drug rider for coverage of oral contraceptives.

Family Planning Infertility

Diagnostic services rendered for infertility evaluation are covered. Any medical treatment and/or prescription related to infertility once diagnosed are excluded by the Plan.

Genetic Testing

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

- You have symptoms or signs of a genetically-linked inheritable disease;
- It has been determined that You are 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 You are undergoing approved genetic testing, or if You have an inherited disease and are a potential candidate for genetic testing.

Habilitative Services

The term "visit" includes any outpatient visit to a Physician's Office or Outpatient Facility during which one or more covered Habilitative Services are provided. Limits on the number of visits provided under the Rehabilitative benefit do NOT apply to Habilitative Services.

Benefits for Habilitative Services designed to assist You to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame are payable up to the maximum number of visits as stated in the Benefit Schedule.

Habilitative Services includes the necessary care and treatment of loss or impairment of speech, payable up to the number of visits as stated in the Benefit Schedule.

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

Special Note:
Additional visits for Habilitative Services may be covered if Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Members's impairment. Cigna must authorize any such additional visits in advance of treatment being provided.

Hearing Aids

Benefits for hearing exams and the following hearing aid services to the limit shown in Benefit Summary:

- New or replacement hearing aids no longer under warranty (Pre-Certification/Prior Authorization required);
- Cleaning or repair;
- Batteries for cochlear implants.

Home Health Care Services

Charges for skilled care provided by certain health care providers during a visit to the home, when the home is determined to be a medically appropriate setting for the services. A visit is defined as a period of 2 hours or less. Home Health Care Services are subject to a maximum of 16 hours in total per day.

Home Health Care Services are covered when skilled care is required under any of the following conditions:

- the required skilled care cannot be obtained in an outpatient facility,
- confinement in a Hospital or Other Health Care Facility is not required,
- the patient's home is determined by Cigna to be the most medically appropriate place to receive specific services.

Covered services include:

- Skilled nursing services provided by a Registered Nurse (RN); Licensed Practical Nurse (LPN); Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse (APRN).
- Services provided by health care providers such as physical therapist; occupational therapist and speech therapist.
- Services of a home health aide when provided in direct support of those nurses and health care providers.
- Necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.
- [Private duty nursing services when determined to be medically necessary.]

[Note: Physical, occupational, and other Outpatient Therapy Services provided in the home are covered under the Outpatient Therapy Services benefit shown in Benefit Summary.]

The following are excluded from coverage:

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

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

Hospice Care Services

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

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

- by a Hospice Facility for 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.

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

- part-time or intermittent nursing care by or under the supervision of a Nurse;
- part-time or intermittent services of an Other Health Care Professional;
- physical, occupational and speech therapy;
- medical supplies;
- drugs and medicines lawfully dispensed only on the written prescription of a Physician;
- laboratory services;

but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Program services are not included as Covered Expenses:

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

Inpatient Services at Other Participating Health Care Facilities

Inpatient services at Other Participating Health Care Facilities including semi-private room and board; skilled and general nursing services; Physician visits; physiotherapy; speech therapy; occupational therapy; x-rays; and administration of drugs, medications, biologicals and fluids.

Internal Prosthetic/Medical Appliances

Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functional body parts are covered, including testicular implants following Medically Necessary surgical removal of testicles. Medically necessary repair, maintenance or replacement of a covered appliance is also covered.

Laboratory and Radiology Services

Laboratory services, radiation therapy, and other diagnostic and therapeutic radiological procedures.

Maternity Care Services

Medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, cesarean section, spontaneous abortion (miscarriage), complications of pregnancy, and maternal risk.

Coverage for a mother and her newly born child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother.

We cover services for maternity care provided by a Physician or midwife, Nurse practitioner, Hospital or birthing center. We cover prenatal care, postnatal care recommended by the USPSTF and HRSA, delivery, and complications of pregnancy. We will not pay for duplicative routine services provided by both a midwife and a Physician.

See the Inpatient Stay for Maternity Care section of this Certificate for coverage of Inpatient maternity care.

We cover breastfeeding support, counseling and supplies, including the cost of renting or the purchase of one (1) breast pump per pregnancy.

These maternity care benefits also apply to the natural mother of a newborn child legally adopted by You in accordance with the Healthplan adoption policies and Arizona law.

These benefits do not apply to the newly born child of an Eligible Dependent daughter unless placement with the Employee is confirmed through a court order or legal guardianship.

Charges incurred at the birth for the delivery of a child only to the extent that they exceed the birth mother's coverage, if any, provided:

- That child is legally adopted by you within one year from date of birth;
- You are legally obligated to pay the cost of the birth;
- You notify the Plan of the adoption within 60 days after approval of the adoption or a change in the insurance policies, plans or company; and
- You choose to file a claim for such expenses subject to all other terms of these medical benefits.

Screening for Diabetes in Pregnancy

We cover screening for diabetes in pregnant women who have not been previously diagnosed with type 1 or 2 diabetes mellitus with the oral glucose challenge test and/or the oral glucose tolerance test, as determined appropriate by a health care provider.

Screening for Diabetes After Pregnancy

We cover screening for diabetes mellitus by oral glucose tolerance test, fasting plasma glucose test, or hemoglobin A1c test in women with a history of gestational diabetes who are not currently pregnant and have not previously been diagnosed with type 2 diabetes, as determined appropriate by a health care provider.

Medical Supplies

Medical supplies include medically appropriate supplies which may be considered disposable, however, are required for a Member in a course of treatment for a specific medical condition. Supplies must be obtained from a Participating Provider. Over the counter supplies, such as band-aids and gauze are not covered.

Mental Health and Substance Use Disorder Services

Important Notice on Mental Health and Substance Use Disorder Coverage

Covered medical services received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to the Mental Health and Substance Use Disorder sections of your plan's Schedule of Benefits.

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

Inpatient services that are provided by a Participating Hospital for the treatment and evaluation of mental health during an inpatient admission are covered. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services

Includes Durable order Services provided by a Participating Hospital or Mental Health Residential Treatment Center for the evaluation and treatment of the psychological and social functional disturbances that are a result of sub-acute Mental Health conditions.

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

A Member 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 Participating Provider or court order.

Outpatient Mental Health Services

Services of Participating Providers who are qualified to treat mental health are covered when treatment is provided on an outpatient basis in an individual, group, structured group, or Mental Health partial hospitalization, or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interferes 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, neuropsychological testing, electroshock, or other convulsive therapy, and medication management when provided in conjunction with a consultation.

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

Mental Health Intensive Outpatient Therapy Program

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 (9) or more hours in a week

Inpatient Substance Use Disorder Rehabilitation Services

Services provided by a facility designated by the Healthplan for rehabilitation 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

Includes voluntary or court-ordered services provided by a Participating Hospital or Substance Abuse Residential Treatment Center 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 (a) specializes in the treatment of psychological and social disturbances that are the result of substance use disorder; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Participating Providers; (c) provides twenty-four (24) hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center. A Member 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 Participating Provider or court order.

Outpatient Substance Use Disorder Rehabilitation Services

Services for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs are covered, including outpatient rehabilitation in an individual, group, structured group, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program.

Substance Use Disorder Partial Hospitalization services are rendered not less than four (4) hours and not more than twelve (12) hours in any twenty-four (24)-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally-authorized agency.

Substance Use Disorder Intensive Outpatient Therapy Program

A Substance Use Disorder Intensive Outpatient Therapy Program consist 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 (9) 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, and medication management when provided in conjunction with a consultation. The Healthplan Medical Director will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Excluded Mental Health and Substance Use Disorder Services

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

- Treatment of chronic conditions not subject to favorable modification according to generally accepted standards of medical practice;
- 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;
- marriage counseling;
- Custodial care, including but not limited to geriatric day care;
- Psychological testing on children requested by or for a school system; and
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline; and
- Biofeedback is not covered for reasons other than pain management.

Medical Foods/Formulas/Medical Supplements

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

We will cover the cost of Gastric Disorder Formula, Medical Foods, and metabolic supplements prescribed to treat inherited metabolic disorders covered under this contract, subject to any applicable Copayments, deductibles or coinsurance.

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

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

For non-inherited disorders, enteral nutrition is considered medically appropriate when the Insured has:

1. A permanent non-function or disease of the structures that normally permit food to reach the small bowel; or
2. A disease of the small bowel which impairs digestion and absorption of an oral diet consisting of solid or semi-solid foods.

The following are not considered medically appropriate and are not covered as a Metabolic Food/Metabolic Supplement, and Gastric Disorder Formula:

1. Standard oral infant formula;
2. Food thickeners, baby food, or other regular grocery products;
3. Nutrition for a diagnosis of anorexia; and
4. Nutrition for nausea associated with mood disorder, and end-stage disease.

Nutritional Evaluation

Nutritional evaluation and counseling from a Participating Provider is covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to:

1. Morbid obesity
2. Diabetes
3. Cardiovascular disease
4. Hypertension
5. Kidney disease
6. Eating disorders
7. Gastrointestinal disorders
8. Food allergies
9. Hyperlipidemia

All other services for the purpose of diet control and weight reduction are not covered unless required by a specifically identified condition of disease etiology. Services not covered include but not limited to: gastric surgery, intra oral wiring, gastric balloons, dietary formulae, hypnosis, cosmetics, and health and beauty aids

Obstetrical and Gynecological Services

Obstetrical and gynecological services that are provided by qualified Participating Providers for pregnancy, well-women gynecological exams, primary and preventive gynecological care and acute gynecological conditions are covered. For these Services and Supplies You have direct access to qualified Participating Providers; You do not need a Referral from Your PCP.

Orthognathic Surgery

Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) are covered if approved as Medically Necessary.

Ostomy Supplies

Ostomy supplies are supplies which are medically appropriate for care and cleaning of a temporary ostomy. Covered supplies include, but are not limited to pouches, face plates and belts, irrigation sleeves, bags and catheters, skin barriers, gauze, adhesive remover, deodorant, pouch covers, and other supplies as appropriate.

Oxygen

Oxygen and the oxygen delivery system.
However, coverage of oxygen that is routinely used on an outpatient basis is limited to coverage within the Service Area. Oxygen Service and Supplies are not covered outside of the Service Area, except on an emergency basis.

Peer Support Services

Peer Support Services are specialized supportive interactions that are performed by trained and certified individuals who are current or past recipients of mental health or substance use services. These services support individuals in their recovery and integration into the community. The goal is to provide understanding and coping skills and empowerment through mentoring and other resources so that individuals with severe and persistent mental health or substance use disorders can cope with stress and achieve personal wellness. Peer support services are provided when medically appropriate.

Preventive Care benefits

- charges made in connection with annual pap test, colorectal cancer screening osteoporosis screening and routine maternity screening;
- Mammograms for breast cancer screening performed on dedicated equipment, including coverage for tomosynthesis, magnetic resonance imaging, ultrasounds, and other modalities for diagnosing breast cancer, on referral by a patient's Physician, not fewer than: a baseline mammogram for women ages 35 to 39, inclusive; a mammogram for women ages 40 to 49, inclusive, every two years or more frequently based on the attending Physician's recommendation; or a mammogram every year for women age 50 and over.
- charges for annual prostate specific antigen (PSA) screening and digital rectal examination (DRE).
- charges for well child visits and immunizations as recommended by the American Academy of Pediatrics.
- charges for an annual well woman exam.
- charges for an annual well man exam.
- Charges made for the following preventive care services:
  (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 Member 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;
    - Screening for Anxiety. We cover annual screening for anxiety in adolescents age 8 to 18 years, with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Treatment and follow-up care for depression is subject to cost sharing.
    - Screening for Depression. We cover annual screening for depression and assessment of suicide risk in adolescents age 12 to 21 years, with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Treatment and follow-up care for depression is subject to cost sharing.
    - Screening for HIV Infection. We cover HIV infection screening for adolescents age 15 to 21 as part of a well-child visit. As well as younger adolescents who are at increased risk for infection, After initial screening, youth at increased risk of HIV infection should be retested annually or more frequently.

  (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.

(5) Counseling for alcohol misuse, breastfeeding/lactation, depression/psychological, genetic, healthy diet/ nutrition, obesity in adults and children, preventative medication, sexually transmitted infections, domestic violence, skin cancer behavioral and tobacco use.

(6) Screening for HIV Infection. We cover HIV infection screening for adults, as determined appropriate by a health care provider. We cover antigen/antibody immunoassays and supplemental testing to differentiate between HIV-1 and HIV-2 antibodies, and HIV-1 nucleic acid tests. See the section on Pregnancy below for screening during pregnancy.

- Preexposure Prophylaxis (PrEP) Related Services

  This Agreement provides coverage without cost for the following services related to PrEP:
  - Education about PrEP;
  - Medical history;
  - Initial HIV testing to determine appropriateness of PrEP;
  - Initial lab work to determine appropriateness of PrEP (i.e. kidney function testing, serologic testing for hepatitis B and Cvirus, testing for other sexually transmitted infections, and pregnancy testing);
  - Follow-up appointment with the healthcare provider for management of side effects;
  - Subsequent lab work and discussion of results;

For Prescription PrEP drug coverage and refills, see the Prescription Drug Rider.

Reconstructive Surgery

Reconstructive surgery or therapy that constitutes necessary care and treatment for medically diagnosed congenital defects and birth abnormalities for newborns, adopted children and children placed for adoption. Additionally, reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement, which is accompanied by functional deficit (other than abnormalities of the jaw or related to TMJ disorder) provided that:

- the surgery or therapy restores or improves function or decreases risk of functional impairment; or
- reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or
- the surgery or therapy is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.

Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the Healthplan Medical Director.

Self-Management Training

Chronic Disease Self-Management Training from a Participating Physician is covered when it has a therapeutic role in the care of a diagnosed chronic disease/condition, including but not limited to:

1. Morbid obesity
2. Diabetes
3. Cardiovascular disease
4. Hypertension
5. Kidney disease
6. Eating disorders
7. Gastrointestinal disorders
8. Food allergies
9. Hyperlipidemia

Telehealth

Benefits are payable for Telehealth if the Health Care Service would be covered were it provided through in person consultation between the Insured Person and a health care provider and if provided to an Insured Person.

"Health care service" means services provided for the following conditions or in the following settings:

- Trauma;
- Burns;
- Cardiology;
- Infectious diseases;
- Mental health disorders;
- Neurologic diseases including strokes;
- Dermatology; and
- Pulmonology

"Telemedicine:"

- Means the interactive use of audio, video or other electronic media for the purpose of diagnosis, consultation or treatment.
- Does not include the sole use of an audio only telephone, a video only system, a facsimile machine, instant messages or electronic mail.

Telehealth does not include the sole use of an EMAIL message or a FAX transmission.

- Telehealth services are subject to Arizona laws that govern prescribing, dispensing, and administering prescription pharmaceuticals and devices, and must comply with Arizona licensure requirements, and any practice guidelines of the Telehealth Advisory Committee on Telehealth Best Practices or, if not addressed, the practice guidelines of a national association of medical professionals promoting access to medical care for consumers via telecommunications technology or other qualified medical professional societies to ensure quality of care.

Treatment for TMJ (Temporomandibular Joint Dysfunction)

Medical services for TMJ disorder, which is the result of: 1) an accident; 2) trauma; 3) a congenital defect; 4) a developmental defect; or 5) pathology; are covered on the same basis as any other medical condition.

Covered expenses include diagnosis and treatment of TMJ that is recognized by the medical or dental profession as effective and appropriate treatment for TMJ, including intra-oral splints that stabilize the jaw joint.

Transplant Services

Human organ and tissue transplant services at designated facilities throughout the United States. Transplant services include solid organ and bone marrow/stem cell procedures. 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, kidney liver, liver, lung, pancreas or intestinal, which includes small bowel, small bowel/liver or multivisceral. Implantation procedures are also covered for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO) ventricular assist device (VAD) and intra-aortic balloon pump (IABP).

All transplant services other than cornea, must be received at a qualified or provisional Cigna LifeSOURCE Transplant Network® facility.

Cornea transplants received at a facility that is specifically contracted with Cigna for this type of transplant are payable at the In-Network benefits 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 hospitalization [,] [and] surgery necessary for removal of an organ[.][and transportation of a live donor [refer to Transplant Travel Services]. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered. Charges for gene therapy products and services directly related to their administration are not covered under the Transplant Services and Related Specialty Care benefit.

Ventricular Assist Device (VAD) implantation procedures are covered at 100% when performed at a Cigna LifeSOURCE Transplant Network® facility with an approved heart transplant program.

Transplant Travel Services

Travel expenses incurred by You in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant Travel benefits are not available for cornea transplants. Benefits for transportation, lodging, and food are available to You only if You are the recipient of a pre-approved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the Member receiving the transplant will include charges for:

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

In addition to You being covered 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 eighteen (18) years of age.

The following are specifically excluded travel expenses:

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

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

[Advanced Cellular therapy

Charges for advanced cellular therapy products and services directly related to their administration are covered when Medically Necessary. Coverage includes the cost of the advanced cellular therapy product; medical, surgical, and facility services directly related to administration of the advanced cellular therapy product, and professional services.

Cigna determines which U.S. Food and Drug Administration (FDA) approved products are in the category of advanced cellular therapy, based on the nature of the treatment and how it is manufactured, distributed and administered. An example of advanced cellular therapy is chimeric antigen receptor (CAR) T-cell therapy that redirects a person's T cells to recognize and kill a specific type of cancer cell.

Advanced cellular therapy products and their administration are covered when prior authorized to be received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services. Advanced cellular therapy products and their administration received from a provider that is not contracted with Cigna for the specific advanced cellular therapy product and related services are not covered.

Advanced Cellular therapy Travel Services
Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized advanced cellular therapy product are covered, subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when:

- you are the recipient of a prior authorized advanced cellular therapy product;
- the term recipient is defined to include a person receiving prior authorized advanced cellular therapy related services during any of the following: evaluation, candidacy, event, or post care;
- the advanced cellular therapy products and services directly related to their administration are received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services; and
- the provider is not available within a [0 – 100] mile radius of your primary home residence.

Travel expenses for the person receiving the advanced cellular therapy include charges for: transportation to and from the advanced cellular therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the 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 [0 – 100] mile radius of your primary home residence; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.]

Vision Screenings

Vision screenings provided by Your PCP.

SECTION V. EXCLUSIONS AND LIMITATIONS

Exclusions

Any Service and Supplies which are not described as covered in "Section IV Covered Services and Supplies" or in an attached Rider or are specifically excluded in “Section IV Covered Services and Supplies” or an attached Rider are not covered under this Agreement.

In addition, the following are specifically excluded Service and Supplies:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public schools system or school district.
3. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.
5. Charges for which You are not obligated to pay or for which You are not billed.

   This exclusion includes, but is not limited to:

   - any instance where the Healthplan determines that a provider or pharmacy did not bill you for, or waived, forgiven or reduced any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Service and Supply (as shown on Benefit Summary of Copayments) without the Healthplan’s express consent.

   - [charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.]

   In the event that the Healthplan determines that this exclusion applies, then the Healthplan in its sole discretion shall have the right to:

   - require you and/or any provider or pharmacy submitting claims on your behalf to provide proof sufficient to the Healthplan that you have made your required cost share payment(s) prior to the payment of any benefits by the Healthplan;
   - deny the payment of benefits in connection with the otherwise Covered Service and Supply, regardless of whether the provider or pharmacy represents that you remain responsible for any amounts that your plan does not cover; or
   - reduce the benefits in proportion to the amount of the charges, Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or pharmacy represents that you remain responsible for any amounts this Agreement does not cover.

6. [Charges or payment for healthcare-related services that violate state or federal law.]
7. 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.
8. Any services and supplies for or in connection with experimental, investigational or unproven services.

Experimental, investigational or unproven services do not include routine patient care costs related to qualified clinical trials as described in Your plan document.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an Institutional Review Board for the proposed use

9. Cosmetic surgery, therapy or surgical procedures primarily for the purpose of altering appearance, except for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem. complaints related to one's appearance. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, the eyelids,

   face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of portion of the body, including, the breast, face, lips, jaw, chin, nose, ears or genital; hair transplantation; chemical face peels or abrasion of the skin; electrolysis diplation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function, or surgery, which is Medically Necessary.

10. The following services are excluded from coverage regardless of clinical indications;

    - Macromastia or Gynecomastia Surgeries;
    - Surgical treatment of varicose veins;
    - Abdominoplasty;
    - Panniculectomy;
    - Rhinoplasty;
    - Blepharoplasty;
    - Redundant skin surgery;
    - Removal of skin tags;
    - Acupressure;
    - Craniosacral/cranial therapy;
    - Dance therapy, movement therapy;
    - Applied kinesiology;
    - Rolfing;
    - Prolotherapy; and
    - Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

11. 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 unless otherwise covered under "Section VI Pediatric Dental Benefits.". However, charges made for services or supplies provided for or in connection with a fractured jaw or an accidental injury to natural teeth are covered.

12. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision unless otherwise covered under "Section IV. Covered Services and Supplies.".

13. Reports, evaluations, physical examinations, or hospitalization not required for health reasons including, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations, unless otherwise covered under this plan.

14. Court ordered treatment or hospitalization, unless prescribed by a Participating Physician and is a Covered Services of Supply covered under "Section IV. Covered Services and Supplies."

15. Infertility services, 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, unless otherwise covered under "Section IV. Covered Services and Supplies."

16. Reversal of male and female voluntary sterilization procedures.

17. Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

18. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.

19. Medical and hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under the Agreement.

20. Non-medical counseling or ancillary services including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, or intellectual disabilities..

21. 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 which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

22. 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 "Inpatient Hospital Services", "Outpatient Facility Services", "Home Health Services", Diabetic Services and Supplies", or "Breast Reconstruction and Breast Prostheses" sections of "Section IV. Covered Services and Supplies."

23. Private hospital rooms and/or private duty nursing except as provided in the "Home Health Services" section of "Section IV. Covered Services and Supplies.", or when deemed medically appropriate by Us. Private duty nursing will not be excluded in an inpatient setting, if skilled nursing is not available.

24. 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 illness or injury.

25. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs, except as provided in the "Diabetic Services and Supplies", "Orthoses or Orthotic Devices", or "External Prosthetic Appliances and Devices" provisions of the "Covered Service and Supplies" section of the Agreement.
26. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
27. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery) unless otherwise covered under "Section VII. Pediatric Vision Benefits.";
28. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy, unless otherwise covered under "Section VII. Pediatric Vision Benefits.";
29. Treatment by acupuncture.
30. All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies."
31. Routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered.
32. Membership costs or fees associated with health clubs, and weight loss programs.
33. Genetic screening or pre-implantation 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.
34. Dental implants for any condition.
35. Fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
36. Blood administration for the purpose of general improvement in physical condition.
37. Cost of biologicals that are immunizations or medications for purposes of travel, or to protect against occupational hazards and risks unless Medically Necessary or indicated, or except for immunizations required for State of Arizona for work related travel.
38. Health and beauty aids, cosmetics and dietary supplements
39. All nutritional supplements formulae enteral feedings, supplies and specifically formulated medical foods, whether prescribed or not, except for infant formula needed for the treatment of inborn errors of metabolism.]Expenses incurred for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
40. Charges related to an Injury or Illness payable under worker's compensation or similar laws.
41. Telephone, email & internet consultations, .massage therapy, educational services except for Diabetes Self-Management Training; counseling educational services for breastfeeding; physician counseling regarding alcohol misuse, preventive medication, obesity, nutrition, tobacco cessation and depression; preventive counseling and educational services specifically required under Patient Protection and Affordable Care Act (PPACA) or and as specifically provided or arranged by Cigna.

42. Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Physician, from any of the following:

- You or your employer;
- A person who lives in the Insured Person's home, or that person's employer;
- A person who is related to the Insured Person by blood, marriage or adoption, or that person's employer; or
- A facility or health care professional that provides remuneration to you, directly or indirectly, or to an organization from which you receive, directly or indirectly, remuneration.

In addition to the provisions of this "Exclusions and Limitations" section, You will be responsible for payments on a fee-for-service basis for Service and Supplies under the conditions described in the "Reimbursement" provision of "Section VI. Other Sources of Payment for Services and Supplies."

Limitations

Circumstance Beyond the Healthplan's Control. To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within Our control results in Our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Agreement, We will make a good faith effort to provide or arrange for the provision of the service or supplies, taking into account the impact of the event.

SECTION VI: PEDIATRIC DENTAL BENEFITS

Following is a Benefit Schedule of the Agreement.

The Pediatric Dental benefits described within the following pages apply to Members up to the age of 19. Benefits will apply until the end of the [calendar year][month] in which this limiting age is reached.

The Agreement sets forth, in more detail, the rights and obligations of both You, Your Dependents and Cigna. It is, therefore, important that all Members **READ THE ENTIRE AGREEMENT CAREFULLY!**

The benefits outlined in the table below show the payment percentages for Covered Expenses **AFTER** any applicable Deductibles have been satisfied unless otherwise stated.

The Benefit Percentage payable for Emergency Services charges made by a Non-Network Dentist is the same Benefit Percentage as for Network Dentist Charges. Dental Emergency services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

Deductibles
Deductibles are expenses to be paid by You or Your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in Benefit Summary has been reached You and Your family need not satisfy any further dental deductible for the rest of that year.

Network Dentist Payment
Network Dentist services are paid based on the Contracted Fee agreed upon by the provider and Cigna.

	Network Dentist
Calendar Year Maximum: Class I, II, III & IV	None
Lifetime Maximum: Class IV	None
Calendar Year Deductible: Class II, III & IV	None
	None
Separate Lifetime Deductible for Class IV	None
Out of Pocket Maximum: Class I, II, III & IV	Combined with Medical
	Combined with Medical

Benefit	Percentage of Covered Expenses the Plan Pays
Class I - Preventive/Diagnostic Services	100%
Class II – Basic Restorative Services	100%
Class III – Major Restorative Services	100%
Class IV _ Medically Necessary Orthodontia	50%
Class V - TMJ	Not Covered
Class IX – Surgical Implants	Not Covered
Reimbursement levels	Based on reduced contracted fees

Definitions

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

Agreement means Cigna HealthCare of Arizona, Inc. Group Service Agreement, Benefit Summary, any Supplemental Riders and any other attachments described herein, the Enrollment Application, and any subsequent amendment or modification to any part of the Agreement.

Calendar Year is a 12-month period beginning each January 1 at 12:01 a.m. [Eastern][local] Time.

Contract Year means the 12-month period beginning at 12:01 a.m. on the first day of the initial term or any renewal term and ending at 12:01 a.m. on the next anniversary of that date.

Cigna. We, Our, and Us mean Cigna Healthcare of Arizona, a Health Care Services Organization (HCSO) or commonly known as an HMO, which is organized under the laws of the State of Arizona, or an affiliate. Cigna is a party to the Agreement.

Coinsurance means the percentage of charges for Covered Expenses that a Member is required to pay under the Agreement.

Contracted Fee. The term Contracted Fee refers to the total compensation level that a Network Dentist has agreed to accept as payment for dental procedures and services
performed on a Member, according to the Member's dental benefit plan.

Covered Expenses are the expenses incurred for Covered Services under this Agreement for which Cigna will consider for payment under this Agreement. Covered Expenses will never exceed the Contracted Fee. In addition, Covered Expenses may be limited by other specific maximums described in this Agreement. Covered Expenses are subject to applicable Deductibles and other benefit limits. An expense is incurred on the date the Member receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Agreement and which are not specifically excluded by the Agreement.

Deductible means the amount of Covered Expenses each Member must pay for Covered Services before benefits are available under this Agreement.

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

Dentist The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a Physician operating within the scope of his license when he performs any of the dental services described in the Agreement.

Dependent means an individual in the Subscriber's family who is enrolled as a Member under this Agreement. You must meet the Dependent eligibility requirements in "Section II. Enrollment and Effective Date of Coverage" to be eligible to enroll as a Dependent.

Effective Date is the date on which coverage under this Agreement begins for You and any of Your Dependents.

Functioning Natural Tooth means a Natural Tooth which is performing its normal role in the mastication (i.e., chewing) process in the Member's upper or lower arch and which is opposed in the Member's other arch by another natural tooth or prosthetic (i.e., artificial) replacement.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

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

Medically Necessary and/or Dentally Necessary Services provided by a Dentist or Physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to You or Your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

Member means an individual meeting the eligibility criteria as a Subscriber or a Dependent who is enrolled for Healthplan coverage and for whom all required Prepayment Fees have been received by the Healthplan. Also referred to as "you" or "your".

Membership Unit means the unit of Members made up of the Subscriber and his Dependent(s).

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development for the body (i.e., not manufactured). Organic portions of a tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp (nerve).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the Member's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with Our dental consultant.

Newborn is an infant within 31 days of birth.

Network Dentist - is a Dentist or a professional corporation, professional association, partnership, or any other entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services at contracted rates with regard to a particular Agreement under which a Member is covered. The providers qualifying as Network Dentist may change from time to time.

Payment for a service delivered by a Network Dentist is the Contracted Fee, times the benefit percentage that applies to the class of service, as specified in Benefit Summary.

The Member is responsible for the balance of the Contracted Fee.

Non-Network Dentist (Out of Network Provider) is a provider who does not have an agreement in effect with Cigna for this Agreement at the time services are rendered. Expenses incurred from a Non-Network Dentist are not covered, except in the case of an emergency or when Cigna otherwise authorizes payment for out-of-network benefits.

Orthodontic Treatment means the corrective movement of the teeth through the alveolar bone by means of an active appliance to correct a handicapping malocclusion of the mouth.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

Subscriber means an employee [or retiree] or a participant in the Group, who is enrolled as a Member under this Agreement. You must meet the requirements contained in "Section II Enrollment and Effective Date of Coverage" to be eligible to enroll as a Subscriber.

You/Your means the Subscriber and/or any of his Dependents**.**

Covered Dental Expense: What the Agreement Pays For

Before this Agreement pays for any benefits, You and Your Dependents must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

The benefits described in the following sections are provided for Covered Expenses incurred while covered under this Agreement. An expense is incurred on the date the Member receives the service or supply for which the charge is made. These benefits are subject to all provisions of this Agreement, some of which may limit benefits or result in benefits not being payable.

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a Member provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;

- the deductible amount in Benefit Summary has been met;
- the maximum benefit in Benefit Summary has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;

For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment.

If a Member requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

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

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

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, Cigna will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $500.

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

Covered Dental Expenses

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

CLASS I Preventive Diagnostic Services.

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
D0391	Interpretation of Diagnostic Image	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
D0426	Collection, preparation, and analysis of saliva sample - point of care	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	2 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1510	Space maintainer - fixed - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1516	Space maintainer - fixed – bilateral, maxillary	Non-orthodontic treatment for prematurely removed or missing teeth.
D1517	Space maintainer - fixed – bilateral, mandibular	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1526	Space maintainer - removable – bilateral, maxillary	Non-orthodontic treatment for prematurely removed or missing teeth.
D1527	Space maintainer - removable – bilateral, mandibular	Non-orthodontic treatment for prematurely removed or missing teeth.
D1551	Re-cementation of space maintainer, maxillary	Non-orthodontic treatment for prematurely removed or missing teeth.
D1552	Re-cementation of space maintainer, mandibular	Non-orthodontic treatment for prematurely removed or missing teeth.
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	Non-orthodontic treatment for prematurely removed or missing teeth.
D1556	Removal of fixed unilateral space maintainer - per quadrant	Non-orthodontic treatment for prematurely removed or missing teeth.

UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II – Basic restorative services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
D2391	Resin-based composite – one surface, posterior	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2929	Prefabricated porcelain crown - primary	1 per tooth in 60 months
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons under 15 years of age.
D2931	Prefabricated stainless steel crown - permanent tooth	. Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons under 15 years of age.
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	

D2976	Band stabilization – per tooth	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members up to age 6 and for primary molars and cuspids for members up to age 11.
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members up to age 6 and for primary molars and cuspids for members up to age 11.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
D7921	Collect – Apply Autologous Product	1 every 36 months
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5511	Repair broken complete denture base, mandibular	
D5512	Repair broken complete denture base, maxillary	
D5520	Replace missing or broken teeth - complete denture (each tooth)	

REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5611	Repair resin denture base, mandibular	
D5612	Repair resin denture base, maxillary	
D5621	Repair cast framework, mandibular	
D5622	Repair cast framework, maxillary	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	

EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	
OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
D7953	Bone replacement graft for ridge preservation – per site	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III – Major restorative services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	Alternate benefit to D2140, 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2520	Inlay - metallic - two surfaces	Alternate benefit to D2150 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2530	Inlay - metallic - three or more surfaces	Alternate benefit to D2160 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2542	Onlay - metallic-two surfaces	1 per tooth every 60 months. Placement must be Dentally Necessary.
D2543	Onlay - metallic-three surfaces	1 per tooth every 60 months. Placement must be Dentally Necessary.
D2544	Onlay - metallic-four or more surfaces	1 per tooth every 60 months. Placement must be Dentally Necessary.
D2610	Inlay–porcelain/ceramic–one surface	1 per tooth every 60 months. Placement must be Dentally Necessary.
D2620	Inlay–porcelain/ceramic–two surface	1 per tooth every 60 months. Placement must be Dentally Necessary.
D2630	Inlay–porcelain/ceramic–three or more surfaces	1 per tooth every 60 months. Placement must be Dentally Necessary.
D2642	Onlay– porcelain/ceramic–two surfaces	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2643	Onlay– porcelain/ceramic–three surfaces	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2644	Onlay– porcelain/ceramic–four or more surfaces	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.

CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	Anterior/Bicuspids: Alternate Benefit to D2751 Molars: Alternate Benefits to D2791 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2750	Crown - porcelain fused to high noble metal	Anterior/Bicuspids: Alternate Benefit to D2751 Molars: Alternate Benefits to D2791 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2751	Crown - porcelain fused to predominantly base metal	Molars: Alternate Benefits to D2791 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2752	Crown - porcelain fused to noble metal	Anterior/Bicuspids: Alternate Benefit to D2751 Molars: Alternate Benefits to D2791 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2780	Crown - 3/4 cast high noble metal	Alternate Benefits to D2781 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2783	Crown - 3/4 porcelain/ceramic	Molars: Alternate Benefits to D2781 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2790	Crown - full cast high noble metal	Alternate Benefits to D2791 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2792	Crown - full cast noble metal	Alternate Benefits to D2791 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.
D2794	Crown - titanium	Alternate Benefits to D2791 1 per tooth per 60 consecutive month period. Placement must be Dentally Necessary.

OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure.
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure.
D2980	Crown repair, by report	
D2981	Inlay Repair	
D2982	Onlay Repair	
D2983	Veneer Repair	
D2990	Resin infiltration/smooth surface	1 in 36 months
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	
ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3355	Pulpal regeneration – initial visit includes opening tooth, preparation of canal Spaces, placement of medication	
D3356	Pulpal regeneration – interim medication replacement	
D3357	Pulpal regeneration – completion of treatment - does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	

D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4212	Gingivectomy or gingivoplasty – with restorative procedures, per tooth	1 every 36 months
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4241	Gingival flap procedure, including root planning – one to three contiguous teeth or tooth bounded spaces per quadrant	1 every 36 months
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4261	Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant	1 every 36 months
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	
D4270	Pedicle soft tissue graft procedure	
D4273	Subepithelial connective tissue graft procedures, per tooth	
D4275	Soft tissue allograft	
D4277	Free soft tissue graft – 1st tooth	
D4278	Free soft tissue graft – additional teeth	
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.

COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 per arch per 60 consecutive month period.
D5120	Complete denture - mandibular	1 per arch per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 per arch per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 per arch per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 per arch per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 per arch per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 per arch per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 per arch per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	1 per arch per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	1 per arch per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5284	Removable unilateral partial denture - one piece flex base (includes retentive/clasp materials, rest & teeth) per quad	1 per arch per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5286	Removable unilateral partial denture - one piece resin (include retentive/clasp material, rests & teeth) per quadrant	1 per arch per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period

D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	
D6113	Implant /abutment supported removable denture for partially edentulous arch - mandibular	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period
D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period
D6057	Custom Abutment	1 every 60 months
D6058	Abutment supported porcelain/ceramic crown	Anterior/Bicuspids: Alternate Benefit to D6060 Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	Anterior/Bicuspids: Alternate Benefit to D6060 Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	Anterior/Bicuspids: Alternate Benefit to D6060 Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	Abutment supported cast metal crown (noble metal)	Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6065	Implant supported porcelain/ceramic crown	Anterior/Bicuspids: Alternate Benefit to D6060 Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	Anterior/Bicuspids: Alternate Benefit to D6060 Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	Anterior/Bicuspids: Alternate Benefit to D6070 Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	Anterior/Bicuspids: Alternate Benefit to D6070 Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	Anterior/Bicuspids: Alternate Benefit to D6070 Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	Anterior/Bicuspids: Alternate Benefit to D6070 Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	Anterior/Bicuspids: Alternate Benefit to D6070 Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6115	Implant /abutment supported fixed denture for edentulous arch - mandibular	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6117	Implant /abutment supported fixed denture for partially edentulous arch - mandibular	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular - Used when a period of healing is necessary prior to fabrication and placement of a permanent prosthetic	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary - Used when a period of healing is necessary prior to fabrication and placement of a permanent prosthetic	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	1 per 60 consecutive month period
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period
D6100	Implant removal, by report	1 per 60 consecutive month period
D6101	Debrideemnt periimplant defect, covered if implants are covered	1 every 60 months
D6102	Debridement and osseous periimplant defect, covered if implants are covered	1 every 60 months

D6103	Bone graft periimplant defect, covered if implants are covered	
D6104	Bone graft implant replacement, covered if implants are covered	
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	Anterior/Bicuspids: Alternate Benefit to D6241 Molars: Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	Anterior/Bicuspids: Alternate Benefit to D6241 Molars: Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	Anterior/Bicuspids: Alternate Benefit to D6241 Molars: Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	Anterior/Bicuspids: Alternate Benefit to D6241 Molars: Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Alternate Benefits to D6545 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	Anterior/Bicuspids: Alternate Benefit to D6751 Molars: Alternate Benefits to D6791 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	Anterior/Bicuspids: Alternate Benefit to D6751 Molars: Alternate Benefits to D6791 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	Alternate Benefits to D6791 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	Anterior/Bicuspids: Alternate Benefit to D6751 Molars: Alternate Benefits to D6791 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	Alternate Benefits to D6781 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	Alternate Benefits to D6781 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	Alternate Benefits to D6781 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	Alternate Benefits to D6791 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	Alternate Benefits to D6791 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6794	Crown - titanium	Alternate Benefits to D6791 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9128	Photobiomodulation therapy **–** first 15 minute increment, or any portion thereof	
D9129	Photobiomodulation therapy - each subsequent 15 minute increment, or any portion thereof	
D9222	Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof	
D9223	Administration of deep sedation/general anesthesia **–** each 15 minute increment, or any portion thereof	
D9239	Administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof	
D9243	Administration of moderate **–** intravenous **–** each subsequent 15 minute increment, or any portion thereof	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 in 12 months. for patients 13 and older**.**
D9944	Occlusal guard – hard appliance, full Arch Removable dental appliance designed to minimize the effects of bruxism or other Occlusal factors. Not to be reported for any Type of sleep apnea, snoring or TMD appliances.	1 per 12 consecutive month period. Allowable for persons 13 to 19 years of age.
D9945	Occlusal guard – soft appliance, full Arch Removable dental appliance designed to minimize the effects of bruxism or other Occlusal factors. Not to be reported for any Type of sleep apnea, snoring or TMD appliances.	1 per 12 consecutive month period. Allowable for persons 13 to 19 years of age.
D9946	Occlusal guard – hard appliance, partial Arch Removable dental appliance designed to minimize the effects of bruxism or other Occlusal factors. Provides only partial Occlusal coverage such as anterior Deprogrammer. Not to be reported for any Type of sleep apnea, snoring or TMD appliances.	1 per 12 consecutive month period. Allowable for persons 13 to 19 years of age.
GENERAL SERVICES		
Claim Code	**Description**	**Frequency**
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	
D9610	Therapeutic drug injection, by report	

Class IV – Medically Necessary Orthodontia

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

Benefits Extension
An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Excluded Services:
Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of "Covered Dental Expenses".
- services provided by a non-Network Dentist without Cigna's prior approval (except in emergencies).
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary
- replacement of lost or missing appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services, unless otherwise covered under "Section IV. Covered Services and Supplies" or "Section VI Pediatric Dental Benefits".
- any charge for any treatment performed outside of the United States other than for Emergency Treatment
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;

- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be Medical Services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations:
No payment will be made for expenses incurred for You or any one of Your Dependents:

- For services or supplies that are not Dentally Necessary.
- For services received before the Effective Date of coverage.
- For services received after coverage under this Agreement ends.
- For services for which You have no legal obligation to pay or for which no charge would be made if You did not have dental insurance coverage.
- For Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Dentist, from any of the following:
    - Yourself or Your employer;
    - a person who lives in the Insured Person's home, or that person's employer.
- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit; for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in Benefit Summary;
- for charges for unnecessary care, treatment or surgery;
- to the extent that You or any of Your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- Procedures that are a covered expense under any other dental plan which provides dental benefits
- To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna will take into account any adjustment option chosen under such part by You or any one of Your Dependents.

Waiting Periods
There are no waiting periods for Pediatric Dental Benefits.

Member Services

If You have any questions or concerns about the Dental Plan, Member Services Representatives are just a toll-free phone call away. They can explain Your benefits or help with matters regarding Your Dental Office or Dental Plan. For assistance with eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices or other matters, call Member Services from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

Notice of Provider Directory/Networks

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

You plan utilizes a network of Dentists, a separate listing of Network Dentists who participate in the network is available to You without charge by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on Your ID card.

Your Provider network consists of a group of local dental practitioners, of varied specialties as well as general practice, who are employed by or contracted with Cigna.

You may also call 1-800-Cigna24 for a list of network Pediatric Dentists.

Administration

The processing of dental claims is administered by Cigna Health & Life Insurance Company.

SECTION VII. OTHER SOURCES OF PAYMENT

FOR SERVICES AND SUPPLIES

Workers' Compensation

Benefits under this Agreement will not duplicate any benefit which the Member is entitled to receive under workers' compensation law. In the event the Healthplan renders or pays for health services which are covered by a workers' compensation plan or included in a workers' compensation settlement. The Healthplan shall have the right to receive reimbursement either (1.) directly from the entity which provides Member's workers' compensation coverage; or (2.) directly from the Member to the extent, if any, that the Member has received payment from such entity, as follows:

1. Where the Healthplan has directly rendered or arranged for the rendering of services the Healthplan shall have a right to reimbursement to the extent of the Prevailing Rates for the care and treatment so rendered.

2. Where the Healthplan does not render services but pays for those services which are within the scope of the "Covered Services and Supplies" section of the Agreement. The Healthplan shall have a right of reimbursement to the extent that the Healthplan has made payments for the care and treatment so rendered.

In addition, it is the Member's obligation to fully cooperate with any attempts by the Healthplan to recover such expenses against the Member's employer in the event that coverage is not available as a result of the failure to the employer to take the steps required by law or regulation in connection with such coverage.

Coordination of Benefits

This section applies if You are covered under another plan besides this health plan and determines how the benefits under the plans will be coordinated. If You are covered by more than one health benefit plan, You should file all claims with each plan.

A. Definitions

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

Plan

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

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

Each type of coverage You have in these three (3) categories shall be treated as a separate Plan. Also, if a Plan has two parts and only one part has coordination of benefit rules, each of the parts shall be treated as a separate Plan.

Closed Panel Plan

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

Primary Plan

The Plan that determines and provides or pays its benefits without taking into consideration the existence of anyother 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 the Reasonable Cash Value of any services it provided to You from the Primary Plan.

Allowable Expense

A necessary, customary, and reasonable health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you; but not including dental, vision or hearing care coverage. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

A plan which takes Medicare or similar government benefits into consideration when determining the applications of its coordination of benefits provision does not expand the definitions of an AllowableExpense.

Claim Determination Period

A calendar year, but it does not include any part of a year during which You are not covered under this Agreement or any date before this section or any similar provision takes effect.

Reasonable Cash Value

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

B. Order of Benefit Determination Rules

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:

1. The Plan that covers You as a Subscriber or an employee shall be the Primary Plan and the Plan that covers You as a Dependent shall be the Secondary Plan;

2. If You are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as a Subscriber or employee;

3. If You are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

    a. first, if a court decree states that one parent is responsible for the child's health care 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;

    b. Then, the Plan of the parent with custody of the child;

    c. Then, the Plan of the spouse of the parent with custody of the child;

    d. Then, the Plan of the parent not having custody of the child, and

    e. Finally, the Plan of the spouse of the parent not having custody of the child.

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

5. The Plan that covers You under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers You as an active employee or retiree (or as that employee's dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

6. If one of the Plans that covers You is issued out of the state whose laws govern this Agreement and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

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

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

C. Effect on the Benefits of this Agreement.

If We are the Secondary Plan, We may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred (100%) percent of the total of all allowable expenses.

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

As to each claim that is submitted, We shall determine the following:

1. Our obligation to provide Service and Supplies under this Agreement;
2. Whether a benefit reserve has been recorded for you; and
3. Whether there are any unpaid Allowable Expenses during the claims determination period.

If there is a benefit reserve, We shall use the benefit reserve recorded for You to pay up to one hundred (100%) percent of the total of all Allowable Expenses. At the end of the Claim Determination Period, Your benefit reserve shall return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination Period.

D. Recovery of Excess Benefits

If We provide Service and Supplies that should have been paid by the Primary Plan or if We provide services in excess of those for which We are obligated to provide under this Agreement, We shall have the right to recover the actual payment made or the Reasonable Cash Value of any services.

We shall have the 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; any insurance company; health care 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 its rights.

E. Right to Receive and Release Information.

We, without consent of or notice to you, may obtain information from and release information to any Plan with respect to You in order to coordinate Your benefits pursuant to this section. You shall provide Us with any information We request in order to coordinate Your benefits pursuant to this section.

F. Injuries Covered under Med Pay Insurance

If You are injured as a result of a motor vehicle accident, and the medical expenses are covered in full or part by a medical payment provision under an automobile insurance policy (Med Pay Insurance), the Med Pay Insurance shall pay first, and the Healthplan shall pay only in the event the amount of Med Pay Insurance is insufficient to pay for those medical expenses. The Healthplan reserves the right to require proof that Med Pay Insurance has paid the full amount required prior to making any payments. Payment for such services and benefits shall be Your responsibility. If the Healthplan paid in excess of their obligation, You may be asked to assist the Healthplan in obtaining reimbursement from Med Pay Insurance for expenses incurred in treating Your injuries.

Health Care Provider Liens

Arizona law prohibits Participating Providers from charging You more than the applicable Copayment or other amount You are obligated to pay under this Agreement for covered services. However, Arizona law also entitles certain Participating Providers to assert a lien for their customary charges for the care and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. This means that if You are injured and have a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, a Participating Provider may be entitled to a lien against available proceeds from any such insurer or payor in an amount equal to the difference between: (1) the applicable Member Copayment plus what the Participating Provider has received from Healthplan as payment for covered services, and (2) the Participating Provider's full billed charges.

SECTION VIII. TERMINATION OF YOUR COVERAGE

We may terminate Your coverage for any of the reasons stated below.

Termination By Reason of Ineligibility

When You fail to meet the eligibility criteria in "Section II. Enrollment and Effective Date of Coverage" as either a Subscriber or Dependent, Your coverage under this Agreement shall cease. Coverage of all Members within a Membership unit shall cease when the Subscriber fails to meet the eligibility criteria. The Group shall notify Us of all Members who fail to meet the eligibility criteria.

Unless otherwise provided by law, if You fail to meet the eligibility criteria Your coverage shall cease at midnight of the day that the loss of eligibility occurs, and We shall have no further obligation to provide Service and Supplies.

Termination By Termination of This Agreement

This Agreement may be terminated for any of the following reasons:

1. Termination for Non-Payment of Fees. We may terminate this Agreement for the Group's non-payment of any Prepayment Fees owed to us.
2. Termination on Notice. The Group, without cause, may terminate this Agreement upon sixty (60) Days prior written notice to us. We, without cause, may terminate this Agreement upon either: (i) ninety (90) Days prior written notice to the Group of Our decision to discontinue offering this particular type of coverage; or (ii) at the renewal date of the plan upon, one hundred eighty (180) Days prior written notice to the Group of Our decision to discontinue offering all coverage in the applicable market. If coverage is terminated in accordance with (i) above, the Group may purchase a type of coverage currently being offered in that market.
3. Termination for Fraud or Misrepresentation. We may terminate this Agreement upon thirty (30) Days prior written notice to the Group if, at any time, We determine that the Group has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact.
4. Termination for Violation of Contribution or Participation Rules. We may terminate this Agreement upon sixty (60) Days prior written notice to the Group if, after the initial twelve (12) month or other specified time period, it is determined that the Group is not in compliance with the participation and/or contribution requirements as established by us.
5. Termination Due to Association Membership Ceasing. If this Agreement covers an association, We may terminate this Agreement in accordance with applicable state or federal law as to a Member of a bona fide association if the Member is no longer a Member of the bona fide association.

Termination Effective Date. Coverage under this Agreement shall terminate at midnight of the date of termination provided in the written notice, except in the case of termination for non-payment of fees, in which case this Agreement shall terminate immediately upon Our notice to the Group.

Notice of Termination to Members. If this Agreement is terminated for reasons #1 or #3 in this section or for loss of eligibility, the Group shall notify You of the termination effective date. If this Agreement is terminated for any other reason by Cigna, We will notify You of the termination effective date. The Group will notify You of any applicable rights You may have under "Continuation of Coverage" section.

Responsibility for Payment. The Group shall be responsible for the payment of all Prepayment Fees due through the date on which coverage ceases. You shall be financially responsible for all services rendered after that date. The Group shall be responsible for providing appropriate notice of cancellation to all Members in accordance with applicable state law. If the Group fails to give written notice to You prior to such date, the Group shall also be financially responsible for, and shall submit to us, all Prepayment Fees due until such date as the Group gives proper notice.

Rescissions

Your coverage may not be rescinded (retroactively terminated) by the Healthplan or the plan sponsor unless: (1) 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 (2) the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

Certification of Creditable Coverage Upon Termination

We will issue You a Certification of Creditable Group Health Plan Coverage as required by law and based on information provided to Us by the Group at the following times:

1. When Your coverage is terminated by reason of ineligibility or You otherwise become covered under "Section X. Continuation of Coverage";
2. When Your continuation coverage, if You elected to receive it, is exhausted; and
3. When You make a request within twenty-four (24) months after the date coverage expires under either of the above two situations; and.
4. When You make a request while You are covered under this Agreement.

Extension of Benefits

We will provide an extension of Your medical benefits, subject to all terms and conditions of this Agreement, for a Member who is eligible for coverage and totally disabled on the date of discontinuance of this Agreement under the section entitled "Termination by Termination of this Agreement" above, if such Member became totally disabled while covered under this Agreement. This extension of benefits shall:

1. provide coverage that is Medically Necessary to treat the disabling condition; and
2. remain in effect until the earlier of the date:
   (i) the Member is no longer totally disabled; or
   (ii) the Member exhausts the maximum benefits available for treatment of the disabling condition; or
   (iii) twelve (12) months after discontinuance of this Agreement.

"Totally disabled" means (for Subscriber or any Dependent who normally works for wage or profit), a medically determinable physical or mental impairment as the result of an injury or illness that renders such Member unable to perform any acts or duties necessary for Member's own occupation, or any other employment or occupation for wage or profit for which Member is qualified by reason of education, training or experience, as determined by Healthplan Medical Director. In the case of any other Dependent, it means the continuing inability, as a result of injury or illness, to perform the normal activities or duties of individuals of like sex and age in good health, as determined by Healthplan Medical Director.

SECTION IX. CONTINUATION OF COVERAGE

Arizona State Continuation for groups with less than 20 employees
This continuation is only applicable when COBRA does not apply.
This continuation applies to covered employees, dependents and domestic partners.
This continuation is not available to any individual who is entitled to COBRA, Medicare, Medicaid, or coverage under another group health plan.

Continuation is available upon the occurrence of any of the following events as indicated which results in loss of coverage under the plan:

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

Special Provisions: Disabled Qualified Dependent:
If a qualified dependent is determined by the Social Security Administration to have a disability at the time of a qualifying event then the qualified dependent may be eligible to continue coverage for an additional eleven months if the qualified dependent provides the written determination of disability from the Social Security Administration to the employer within sixty days after the date of that determination and before the end of the eighteen month continuation period. The qualified dependent shall notify the employer within thirty days after the Social Security Administration determines that the qualified dependent no longer has a disability.

Notice of the right to elect continuation must be sent in writing by the employer to the individual within thirty days after the qualifying event.

A qualified individual must elect continuation of coverage under this state law within sixty days after the date of the notice and submit the first month premium to the employer within forty five days after the date of election to continue coverage.

A qualified individual may continue coverage for a maximum of 18 months after the date the continuation coverage begins. If a qualifying event occurs during the eighteen month continuation period, a qualified dependent may be eligible to continue coverage for an additional eighteen months

Special Provisions:

- If the enrollee or qualified dependent elects coverage, coverage continues as if there had been no interruption.
- If the employer fails to provide complete, accurate and timely notice of the right to continue coverage, the enrollee has one hundred twenty days after the date of the notice to elect continuation coverage and pay the required premium and administrative fee.
- If an insurance renewal occurs during the enrollee's or qualified dependent's period of eligibility for continuation coverage, the employer shall notify the enrollee or qualified dependent of any change to the premium due at least thirty days before the change is effective.

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

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

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

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

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

If an enrollee is in the military reserve or national guard and is called to active duty, the following events are qualifying events distinct from the qualifying event that may have occurred when the enrollee was called to active duty:
1. The enrollee dies during the period of active duty.
2. A divorce or legal separation of the enrollee from the enrollee's spouse occurs.
3. A dependent child ceases to be a dependent child under the requirements of the employer's health benefits plan.

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

Continuation of Group Coverage under COBRA

Introduction

This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You and to other Members of Your family who are covered under the Plan when You would otherwise lose Your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it. This notice gives only a summary of Your COBRA continuation coverage rights. For more information about Your rights and obligations under the Plan and under federal law, You should either review the Plan's Summary Plan Description *or* get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator information is provided on the page titled "ERISA Summary Plan Description," if applicable. Please contact the Plan Administrator for the name, address and phone number of the Plan's COBRA Administrator.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees and Dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or
(2) Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced or legally separated from Your spouse.

Your Dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his gross misconduct;
(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the Plan as a "Dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), or, if the Plan provides retiree coverage, commencement of a proceeding in bankruptcy with respect to the Employer, the employer must notify the Plan Administrator of the qualifying event within 30 Days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), You must notify the Plan Administrator. The Plan requires You to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to Your Employer.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), Your divorce or legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to 36 months from the date of the qualifying event.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months from the date of the qualifying event. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

If the Plan provides retiree health coverage

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan. Coverage will continue until: (a) for you, Your death; and (b) for Your Dependent surviving spouse or Dependent child, up to 36 months from Your death.

Disability extension of 18-month period of continuation coverage

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 Days of COBRA continuation coverage and You notify the Plan Administrator in a timely fashion, You and Your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months from the date of the initial qualifying event. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 Days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator. You must provide a copy of the Social Security Administration's determination. Termination of coverage for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled.

Termination for this reason will occur on the first day of the month beginning no more than 30 days after the date of the final determination. Please refer to "Early Termination of COBRA Continuation" below for additional circumstances under which COBRA continuation may terminate before the end of the maximum period of coverage.

Second qualifying event extension of 18-month period of continuation coverage

If Your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and Dependent children in Your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months from the initial qualifying event. This extension is available to the spouse and Dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child. **In all of these cases, You must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.**

Early Termination of COBRA Continuation

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Cost of COBRA Continuation Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%). If You or Your Dependents experience a qualifying event, the Plan Administrator will send You a notice of continuation rights, which will include the required premium.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If You have questions about these newtax provisions, You may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at **www.doleta.gove/tradeact/2002act_index.asp**.

Conversion Available Following Continuation

If the Plan provides for a conversion privilege, the plan must offer this option within 180 Days following the maximum period of continuation. However, no conversion will be provided if the qualified beneficiary does not maintain COBRA continuation coverage for the maximum allowable period or does not otherwise meet the eligibility requirements for a conversion plan.

Service Area Restrictions

This plan includes a Service Area restriction which requires that all enrolled participants and beneficiaries receive services in the Employer's Service Area. This restriction also applies to COBRA continuation coverage. If You or Your Dependents move outside the Employer's Service Area, COBRA continuation coverage under Your current plan in Your new location will be limited to Emergency Services only. To obtain coverage for non-Emergency Services, You must obtain such services from a network provider in the Employer's Service Area. If Your Employer offers other benefit options that are available in Your new location, You may be allowed to obtain COBRA continuation coverage under that option. If You or Your Dependent is moving outside the Employer's Service Area, please contact Your Employer for information on the availability of other plan options.

If You Have Questions

If You have questions about Your COBRA continuation coverage, You should contact the Plan Administrator, or You may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa**.

Keep Your Plan Informed of Address Changes

In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

IMPORTANT NOTICE

COBRA BENEFITS WILL ONLY BE ADMINISTERED ACCORDING TO THE TERMS OF THE CONTRACT. THE HEALTHPLAN WILL NOT BE OBLIGATED TO ADMINISTER OR FURNISH ANY COBRA BENEFITS AFTER THE CONTRACT HAS TERMINATED.

Conversion to Non-Group (Individual) Coverage

If You have properly elected and completed any COBRA continuation or other continuation coverage (i.e. completed the maximum coverage period under the continuation coverage), You may apply to the Healthplan for conversion to non-group (individual) coverage. If You do not elect, fail to properly elect or fail to complete any COBRA continuation coverage or other continuation coverage for which You are eligible, conversion to non-group coverage is not available to you.

You must continue to reside in the Service Area in order to be eligible for non-group (individual) coverage. You may apply for non-group (individual) coverage as follows:

A. Conversion After Loss of Subscriber Eligibility

If you, as the Subscriber, are no longer eligible for coverage under this Agreement for any reason other than the reasons stated in the "Termination of Agreement" provisions of "Section IX. Termination of Your Coverage," you may apply for conversion to non-group (individual) coverage. You must apply and pay the applicable Prepayment Fee within thirty-one (31) Days of the loss of group coverage. At the time of conversion to non-group (individual) coverage, You may also apply for non-group (individual) coverage for Dependents who were Members at the time of Your loss of eligibility. If Your application and all non-group fees, including all fees for the period since the termination of group coverage, are submitted within thirty-one (31) Days of the loss of group coverage Your non-group (individual) coverage will be effective as of the date of such termination.

B. Conversion Upon Death or Divorce of Subscriber

If You are a Dependent who has lost eligibility for coverage under this Agreement due to the death or divorce of the Subscriber, you may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

C. Conversion Upon Meeting Age Limitation

If You are a Dependent who has lost eligibility for coverage under this Agreement due to Your attainment of an age limit A of this section.

D. Conversion After Expiration of COBRA or Other Continuation Coverage

A Member whose COBRA or other continuation coverage has expired after the maximum coverage period, may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

The Service and Supplies, terms and conditions of the non-group (individual) coverage, including premiums, Copayments and deductibles, if any, shall be in accordance with the rules of Healthplan in effect at the time of conversion and will not necessarily be identical to the Service and Supplies provided under this Agreement.

Continuation of Coverage Under FMLA

If the Group is subject to the requirements of FMLA (the federal law known as Family and Medical Leave Act of 1993, as amended), the Subscriber shall have coverage under this Agreement during a leave of absence if the Subscriber is an eligible employee under the terms of FMLA and the leave of absence qualifies as a leave of absence under FMLA.

In such a case, the Subscriber shall pay to the Group the portion of the Prepayment Fee, if any, that the Subscriber would have paid had the Subscriber not taken leave and the Group shall pay the Healthplan the Prepayment Fee for the Subscriber as if the Subscriber had not taken leave.

NOTICE OF FEDERAL REQUIREMENTS - UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to military leaves of absence. These requirements apply to medical coverage for You and Your Dependents.

Continuation of Coverage

You may continue coverage for yourself and Your Dependent 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 apply or return to work; and
- the date the policy cancels.

Your employer may charge You and Your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, You may convert to a plan of individual coverage according to any "Conversion Privilege" shown in Your certificate.

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

No Surprises -Continuity of Care/Transition of Care

If a Participating Provider's network status changes to non-Participating; We will provide patients with complex care needs with a 90-day period of continued coverage at the in-network cost sharing rates to allow for a transition of care to a Participating Provider or until the patient no longer requires continuing care.

A "continuing care patient" is an individual who is:

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

A "serious and complex condition" is:

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

A Provider furnishing services to a continuing care patient must accept payment from Us and Cost Sharing from the Member as payment in full for such services.

The Provider must also continue to adhere to all policies, procedures, and quality standards imposed by the HealthPlan in the same manner as if contract termination had not occurred.

No Surprises – Air Ambulance

If You receive air ambulance services from a non-Participating Provider that would be covered by a Participating Provider, the in-network cost share will be applied. Any coinsurance or deductible will be based on rates that would apply if the services were furnished by a Participating Provider. Non-Participating air ambulance Providers are prohibited from surprise balance billing You. Cost Sharing amounts for non-Participating air ambulance services will be counted towards the medical deductible and Out-of-Pocket maximum for the Plan Year.

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

No Surprises – Balance Billing

The federal No Surprises Act prohibits non-Participating Providers and facilities from surprise balance billing patients for more than their in-network Cost Sharing amount for Emergency Services.

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

Customer cost sharing payments for non-Participating Emergency Services must be counted toward any medical deductible or Out-of-Pocket Maximums applied under the Agreement, in the same manner as if the Emergency Services were rendered by a Participating provider or facility.

SECTION X. MISCELLANEOUS

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. Contact the Healthplan Member Services for a list of currently available programs, participating businesses, and other details regarding such arrangements. These programs may include discounts on the following types of services:

- Health Club/GYM Memberships
- Tai-Chi Classes
- Weight Loss Program
- Alternative Care, including Massage Therapy
- Health Food Stores
- Over the Counter Medications
- Vision Products and Services
- Hearing Aids and Services
- Wellness Classes-Selected classes may be offered to Our Members for a Copayment at participating Cigna HealthCare Centers
- Cigna HealthCare Healthy Babies Program®

These programs are provided for the benefit of Cigna HealthCare Members, and are not an endorsement of the services or vendors listed. Discounts are subject to change or elimination upon sixty(60) Days' prior notice.

Administrative Policies Relating to this Agreement

We may adopt reasonable policies, procedures, rules and interpretations that promote orderly administration of this Agreement.

Assignability

The benefits under this Agreement are not assignable unless agreed to by the Healthplan. The Healthplan may, at its option, make payment to the Subscriber for any cost of any covered Services and Supplies received by the Subscriber or Subscriber's covered Dependents from a non-Participating Provider. The Subscriber is responsible for reimbursing the non-Participating Provider.

Clerical Error

No clerical error on the part of the Healthplan shall operate to defeat any of the rights, privileges or benefits of any Member.

Entire Agreement

This Agreement constitutes the entire Agreement between the Healthplan, the Group, and Members and supersedes any previous agreement. Only an officer of the Healthplan has authority to waive any conditions or restrictions of this Agreement, extend the time for making payment, or bind the Healthplan by making any promise or representation, or by giving or receiving any information. No change in the Agreement shall be valid unless stated in a Rider or an amendment attached hereto signed by an officer of the Healthplan. In the event of any direct conflict between information contained in the Group Service Agreement and other collaterals, the terms of the Group Service Agreement shall govern.

No Implied Waiver

Failure by the Healthplan, the Group, or a Member to avail themselves of any right conferred by this Agreement shall not be construed as a waiver of that right in the future.

Notice

The Healthplan, the Group, and the Member shall provide all notices under this Agreement in writing, which shall be hand-delivered or mailed, postage pre-paid, through United States Postal Service to the addresses set forth on the Cover Sheet.

Records

The Healthplan maintains records regarding Members, but the Healthplan shall not be liable for any obligation dependent upon information from the Group prior to receipt by the Healthplan in a form satisfactory to the Healthplan. Incorrect information furnished by the Group may be corrected, if the Healthplan shall not have acted to its prejudice by relying on it. All records of the Group and the Healthplan that have a bearing on coverage of a Member shall be open for review by the Healthplan, the Group or the Member at any reasonable time.

Severability

If any term, provision, covenant or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of this Agreement shall remain in full force and effect and shall in no way be affected, impaired, or invalidated.

Successors and Assigns

This Agreement shall be binding upon and shall inure to the benefit of the successors and assigns of the Group and the Healthplan, but shall not be assignable by any Member.

Service Marks

The Cigna HealthCare 24 Hour Health Information Line [SM] and Cigna LIFESOURCE Transplant Network® are registered service marks of Cigna Corporation.

Discrimination is Against the Law

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

Cigna:

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

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

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

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

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

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

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

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

Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FEDERAL REQUIREMENTS

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

Notice Regarding Provider Directories and Provider Networks

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

Qualified Medical Child Support Order Defined

- a Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:
- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

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

Payment of Benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

Coverage will terminate on the earlier of:

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

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

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

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

Consult your Employer for other permitted coverage changes.

Effect of Section 125 Tax Regulations on This Plan

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

A. Coverage elections

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

- if you meet Special Enrollment criteria and enroll as described in the Special Enrollment section; or
- if your Employer agrees, and you meet the criteria shown in the following Sections B through H and enroll for or change coverage within the time period established by your Employer.

B. Change of status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;

- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court order

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

D. Medicare or Medicaid eligibility/entitlement

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

E. Change in cost of coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.
When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

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

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

G. Reduction in work hours

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

H. Enrollment in a Qualified Health Plan (QHP)

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

Family: A plan may allow an Employee to revoke family coverage midyear in order for family members ("related individuals") to enroll in a QHP through an Exchange (Marketplace). The related individual(s) must be eligible for a Special Enrollment Period to enroll in a QHP or seek to enroll in a QHP during the Marketplace's annual open enrollment period, and the disenrollment from the group plan corresponds to the intended enrollment of the individual(s) in a QHP new coverage effective beginning no later than the day immediately following the last day of the original coverage. If the Employee does not enroll in a QHP, the Employee must select self-only coverage or family coverage including one or more already-covered individuals.

Eligibility for Coverage for Adopted Children

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

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

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

Coverage for Maternity Hospital Stay

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

Women's Health and Cancer Rights Act (WHCRA)

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

Group Plan Coverage Instead of Medicaid

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

Obtaining a Certificate of Creditable Coverage Under This Plan

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call Eligibility Services at 1-800-Cigna24 or 1-800-244-6224.

Coordination with Medicare

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

Eligibility for Medicare

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

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

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

Continuation of Health Insurance During Leave

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

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

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

Reinstatement of Canceled Insurance Following Leave

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

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

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

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

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

Continuation of Coverage

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

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

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

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

Reinstatement of Benefits (applicable to all coverages)

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

Claim Determination Procedures under ERISA

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

Procedures Regarding Medical Necessity Determinations

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

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

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

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

Preservice Determinations

When you or your representative requests a required prior authorization, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna’s control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more 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's reviewer, in consultation with the treating health care professional, will decide if an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

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

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

Concurrent Determinations

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

Postservice Determinations

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

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

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

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

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

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

No Surprises – Air Ambulance
If You receive air ambulance services from an Out-of-Network Provider that would be covered by an In-Network Provider, the in-network cost share will be applied. Any coinsurance or deductible will be based on rates that would apply if the services were furnished by an In-Network Provider. Out-of-Network air ambulance Providers are prohibited from surprise balance billing You. Cost Sharing amounts for Out-of-Network air ambulance services will be counted towards the In-Network deductible and Out-of-Pocket maximum for the Plan Year.

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

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

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

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

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

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

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

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

Who is Entitled to COBRA Continuation?

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

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

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

Secondary Qualifying Events

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

Disability Extension

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

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

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

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

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

Medicare Extension for Your Dependents

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

Termination of COBRA Continuation

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

Employer's Notification Requirements

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

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

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

- if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;

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

How to Elect COBRA Continuation Coverage

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

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

How Much Does COBRA Continuation Coverage Cost?

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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

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

Grace periods for subsequent payments

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

You Must Give Notice of Certain Qualifying Events

- If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:
  - Your divorce or legal separation; or
  - Your child ceases to qualify as a Dependent under the Plan.
  - the occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

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

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

Newly Acquired Dependents

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

COBRA Continuation for Retirees Following Employer's Bankruptcy

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

Interaction With Other Continuation Benefits

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

Clinical Trials

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

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

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

The clinical trial must meet the following requirements:

The study or investigation must:

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

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

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

Routine patient care costs do not include:

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

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

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

ERISA Required Information, for Plans subject to ERISA

You may contact your employer for the following information:

- Plan Name and Number.
- Employer Name and Employer Identification Number (EIN).
- Name, address, ZIP code and business telephone number of the Plan Sponsor and Administrator.
- Name, address and ZIP code of the person designated as agent for service of legal process.
- The claim office responsible for this Plan, and the office designated to consider the appeal of denied claims.
- The cost of the Plan.
- The Plan’s fiscal year end.
- A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

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

Plan Type
The plan is a healthcare benefit plan.

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

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

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

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

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

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

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

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

Receive Information About Your Plan and Benefits

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

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

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

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

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