Seton Hall University

POINT OF SERVICE MEDICAL
BENEFITS

EFFECTIVE DATE: January 1, 2015

CN017
3334085

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

Printed in U.S.A.

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Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

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

POLICYHOLDER: Seton Hall University

GROUP POLICY(S) — COVERAGE
3334085 - NTPOS POINT OF SERVICE MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2015

THIS CERTIFICATE IS SUBJECT TO THE LAWS OF THE STATE OF NEW JERSEY.

This certificate contains pre-admission certification and continued stay review provisions. Benefits under this certificate may be reduced in the event of noncompliance with the requirements of these provisions.

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

Anna Krishtul
Anna Krishtul, Corporate Secretary

Explanation of Terms

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

The Schedule

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

Special Plan Provisions

Case Management

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

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

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

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

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Notice Regarding Emergency Services and Urgent Care

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 need to call your PCP as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a Hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization. Participating Providers are on call 24 hours a day, seven days a week to assist you when you need Emergency Services.

If you receive Emergency Services outside the service area, you must notify the Review Organization as soon as reasonably possible. The Review Organization 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.

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 Review Organization.

Urgent Care Outside the Service Area

In the event you need Urgent Care while outside the service area, you should, whenever possible, contact your PCP for direction and authorization prior to receiving services.

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 or upon prior authorization by the Review Organization.

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Important Notices

Notice of Grandfathered Plan Status

This plan is being treated as a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the phone number or address provided in your plan documents, to your employer or plan sponsor or an explanation can be found on Cigna's website at http://www.Cigna.com/sites/healthcare_reform/customer.html.

If your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If your plan is a nonfederal government plan or a church plan, you may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

HC-NOT4 01-11

Important Information

Mental Health Parity and Addiction Equity Act

The Certificate is amended as stated below:

In the event of a conflict between the provisions of your plan documents and the provisions of this notice, the provisions that provide the better benefit shall apply.

The Schedule and Mental Health and Substance Abuse Covered Expenses:

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

Mental Health and Substance Abuse Services

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

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

Inpatient Mental Health Services

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

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

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

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

Outpatient Mental Health Services are Services of Providers who are qualified to treat Mental Health when treatment is

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

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

Inpatient Substance Abuse Rehabilitation Services

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

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

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

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

Outpatient Substance Abuse Rehabilitation Services

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

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

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

Substance Abuse Detoxification Services

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

Mental Health and Substance Abuse Exclusions:

The following exclusion is hereby deleted and no longer applies:

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

Terms within the agreement:

The term “mental retardation” within your Certificate is hereby changed to “intellectual disabilities”.

Visit Limits:

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

HC-NOT69 12-14

Important Notice

Your health plan provides that you will not be held financially liable for payments to health care providers for any sums, other than required copayments, coinsurance or deductibles, owed for covered expenses, if Cigna fails to pay for the covered expenses for any reason.

If you or your dependent(s) are in need of emergency care, whether or not you use a participating provider in the network, your covered expenses will be reimbursed to you as if you or your dependent(s) had been treated by a preferred provider.

Statement of Rights of Insured Persons

You have the right to be provided with information concerning Cigna’s policies and procedures regarding products, services, providers, appeals procedures and other information about the organization and the care provided.

You have the right to obtain a current directory of preferred providers in the Cigna network upon request, including addresses and telephone numbers, and a listing of providers who accept covered persons who speak languages other than English.

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How To File Your Claim

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

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

CLAIM REMINDERS

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

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

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service. If claims are not submitted within one year, the claim will not be considered valid and will be denied. However, if proof of loss is not given in the time period stated in the paragraph, the claim will not be invalidated nor reduced if it is shown that proof of loss was given as soon as reasonably possible.

WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 25 hours a week; and
- you pay any required contribution.

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

Eligibility for Dependent Insurance

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

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

Waiting Period

Faculty: Date of Hire

Administration & Staff: First of the month following 30 days of employment.

Classes of Eligible Employees

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

Effective Date of Employee Insurance

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

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

Late Entrant - Employee

You are a Late Entrant if:

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

Dependent Insurance

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

Effective Date of Dependent Insurance

Insurance for your Dependents will become eff

ective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

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

Exception for Newborns

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

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Important Information About Your Medical Plan

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

Primary Care Physician

Choice of Primary Care Physician:

When you elect Medical Insurance, you will select a Primary Care Physician for yourself and your Dependents from a list provided by Cigna. The Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Primary Care Physician's Role/Your Responsibility:

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

You and your Dependents are responsible for contacting and obtaining the authorization of the Primary Care Physician, as required, prior to seeking medical care. (You are responsible for obtaining such authorization on behalf of a Dependent who is a minor.)

Changing Primary Care Physicians:

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

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

Direct Access for OB/GYN Services

Female insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for covered OB/GYN services. There is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Provider of your choice for pregnancy, well-woman gynecological exams, primary and preventive gynecological care, and acute gynecological conditions.

Direct Access for Chiropractic Care Services

Insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for In-Network covered Chiropractic Care services. There is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Provider of your choice for Chiropractic Care.

Direct Access for Mental Health and Substance Abuse Services

Insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for covered Mental Health and Substance Abuse Services. There is no requirement to obtain an authorization of care from your Primary Care Physician for individual or group therapy visits to the Participating Provider of your choice for Mental Health and Substance Abuse.

Continuity of Care

When a New Jersey licensed Physician who began treatment for a Sickness or Injury is no longer contracted with the plan, (except that Physician who has been subject to disciplinary

action by the State Board of Medical Examiners) you may continue to see that Physician for the following extended period of time and for the following conditions:

- postop follow-up care – a maximum of 6 months;
- oncological treatment – a maximum of 1 year;
- psychiatric treatment – a maximum of 1 year;
- obstetrical care – throughout the pregnancy plus 6 weeks postdelivery; and
- other health care services when Medically Necessary – a maximum of 120 days.

The continuation of care with the same Physician is at the option of the insured and the same processes and procedures will apply as if the Physician was still a participating provider (for example, authorization will still be required).

Point of Service Medical Benefits

The Schedule

For You and Your Dependents

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

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

Coinsurance

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

Copayments/Deductibles

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

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the benefit plan because of any:

- Coinsurance.
- Copayments or Deductibles.

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

Accumulation of Plan Out-of-Pocket Maximums

Out-of-Pocket Maximums will cross-accumulate (that is, In-Network will accumulate to Out-of-Network and Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) also cross-accumulate between In- and Out-of-Network unless otherwise noted. All In-Network services must be performed by the Primary Care Physician (PCP), referred by the PCP or approved by the local Healthplan.

Guest Privileges

If you or one of your Dependents will be residing temporarily in another location where there are In-Network Providers, you may be eligible for Point of Service Medical Benefits at that location. However, the benefits at the host location may differ from those described in this certificate. Refer to your Benefit Summary from the host location or contact your Employer for more information.

Point of Service Medical Benefits

The Schedule

Multiple Surgical Reduction (Out-of-Network)

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

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

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

Co-Surgeon

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

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
The Percentage of Covered Expenses the Plan Pays **Note:** "No charge" means an insured person is not required to pay Coinsurance.	100%	70%
Maximum Reimbursable Charge Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or **Mental Health and Substance Abuse** A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected.	Not Applicable	200th Percentile

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK

Medical Charges
A policyholder-selected percentage of a schedule developed by the Insurance Company that is based upon a methodology similar to the methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market. (The Insurance Company may apply a rate higher than the Medicare allowable rate.)
A Medicare based schedule will not be used in determining the Maximum Reimbursable Charge for:
• charges made by providers not participating in Medicare or that do not submit their Medicare ID with the claim;
• Covered Services for which Medicare has not established a rate; and
• the following Covered Services until such time as the Insurance Company has implemented a Medicare-based schedule for them: certain ambulance services, treatment of end state renal disease, Home Health Care, Skilled Nursing Facility, and inpatient rehabilitation.
In these situations:
• the Maximum Reimbursable Charge is determined based on the lesser of:
  • the provider's normal charge for a similar service or supply; or
  • the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company.
(Excludes Mental Health and Substance Abuse)
	Not Applicable	200%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Note: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.		
Calendar Year Deductible		
Individual	Not Applicable	$5,000 per person
Family Maximum	Not Applicable	$10,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.		
Out-of-Pocket Maximum		
Individual	$1,000 per person	$8,000 per person
Family Maximum	$2,000 per family	$16,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office Visit	No charge after $10 per office visit copay	70% after plan deductible
Specialty Care Physician's Office Visits	No charge after $10 Specialist per office visit copay	70% after plan deductible
Consultant and Referral Physician's Services		
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.		
Surgery Performed in the Physician's Office	No charge after the $10 PCP or $10 Specialist per office visit copay	70% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	No charge	No charge
Allergy Treatment/Injections	No charge after either the $10 PCP or $10 Specialist per office visit copay or the actual charge, whichever is less	70% after plan deductible
Allergy Serum (dispensed by the Physician in the office)	No charge	70% after plan deductible
Preventive Care (according to USPSTF recommendations) – all ages • Cholesterol screenings for lipid disorders • Immunizations (including lead poisoning screening for children, medical follow-up care and treatment) and physical examinations • Pneumococcal and influenza vaccinations • Alcohol misuse and behavioral counseling interventions • Tobacco use screening of adults and tobacco cessation interventions	No charge	70% after plan deductible
Mammograms, PSA, PAP Smear		
Preventive Care Related Services (i.e. "routine" services)	No charge	70% after plan deductible
Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray & lab benefit; based on place of service	Subject to the plan's x-ray & lab benefit; based on place of service

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital - Facility Services	No charge	70% after plan deductible
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	No charge	70% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	No charge	70% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	No charge	70% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	No charge	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services		
Physician's Office Visit	No charge after the $10 PCP or $10 Specialist per office visit copay	No charge after the $10 PCP or $10 Specialist per office visit copay
Hospital Emergency Room	No charge after $75 per visit copay (Copay waived if admitted)	No charge after $75 per visit copay (Copay waived if admitted)
Outpatient Professional Services (radiology, pathology, ER physician)	No charge	No charge
Urgent Care Facility or Outpatient Facility	No charge after $35 per visit copay (Copay waived if admitted)	No charge after $35 per visit copay (Copay waived if admitted)
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	No charge	No charge
Independent X-ray and/or Lab Facility in conjunction with an ER visit	No charge	No charge
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	No charge	No charge
Ambulance	No charge	No charge
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 90 days combined No prior hospitalization required	No charge	70% after plan deductible
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office Visit	No charge	70% after plan deductible
Outpatient Hospital Facility	No charge for facility charges; no charge for outpatient professional charges	70% after plan deductible
Independent X-ray and/or Lab Facility	No charge	70% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Physician's Office Visit	No charge	70% after plan deductible
Inpatient Facility	No charge	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: 60 days for all therapies combined Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Note: The Short-Term Rehabilitative Therapy maximum does not apply to the treatment of autism.	No charge after the $10 PCP or $10 Specialist per office visit copay **Note:** The Outpatient Short Term Rehab copay does not apply to services provided as part of a Home Health Care visit.	70% after plan deductible
Self-Referral Chiro Calendar Year Maximum: 30 days Physician's Office Visit	No charge after the $10 PCP or $10 Specialist per office visit copay	70% after plan deductible
Home Health Care Calendar Year Maximum: 100 days (includes outpatient private nursing when approved as medically necessary)	No charge	70% after plan deductible
Hospice Inpatient Services Outpatient Services (same coinsurance level as Home Health Care)	No charge No charge	70% after plan deductible 70% after plan deductible
Bereavement Counseling Services provided as part of Hospice Care Inpatient Outpatient Services provided by Mental Health Professional	No charge No charge Covered under Mental Health Benefit	70% after plan deductible 70% after plan deductible Covered under Mental Health Benefit

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services		
Initial Visit to Confirm Pregnancy **Note:** OB/GYN providers will be considered either as a PCP or Specialist depending on how the provider contracts with the Insurance Company.	No charge after the $10 PCP or $10 Specialist per office visit copay	70% after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	No charge	70% after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	No charge after the $10 PCP or $10 Specialist per office visit copay	70% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	No charge	70% after plan deductible
Abortion Includes only non-elective procedures		
Physician's Office Visit	No charge after the $10 PCP or $10 Specialist per office visit copay	70% after plan deductible
Inpatient Facility	No charge	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible
Physician's Services	No charge	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Family Planning Services Physician's Office Visits (tests, counseling) Note: The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office. Excludes: Surgical Sterilization Procedures for Vasectomy/Tubal Ligation	No charge after the $10 PCP or $10 Specialist per office visit copay	70% after plan deductible
Infertility Treatment Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • GIFT Coverage will not be provided for the following services, which do not restore fertility or correct an infertility condition: • Artificial Insemination, In-vitro, ZIFT, etc.		
Physician's Office Visit (Lab and Radiology Tests, Counseling)	No charge after the $10 PCP or $10 Specialist per office visit copay	70% after plan deductible
Inpatient Facility	No charge	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible
Physician's Services	No charge	70% after plan deductible
Lifetime Maximum: 4 complete egg retrievals Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Organ Transplants Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	No charge after the $10 PCP or $10 Specialist per office visit copay	70% after plan deductible
Inpatient Facility	No charge	70% after plan deductible
Inpatient Physician's Services	No charge	70% after plan deductible
Lifetime Travel Maximum: $10,000 per transplant	No charge	No charge
Durable Medical Equipment Calendar Year Maximum: Unlimited	No charge	70% after plan deductible
External Prosthetic Appliances Calendar Year Maximum: Unlimited	No charge	70% after plan deductible
Hearing Aid Maximum Up to $1,000 per hearing aid for each hearing impaired ear every 24 months for a dependent child under age 16. **Note:** Dollar Maximum only applies to services performed Out-of-Network.		
Diabetic Equipment Calendar Year Maximum: Unlimited	No charge	70% after plan deductible
Diabetic Medications	$10 copay	70% after plan deductible
Nutritional Evaluation Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of diabetes.		
Physician's Office Visit	No charge after the $10 PCP or $10 Specialist per office visit copay	70% after plan deductible
Inpatient Facility	No charge	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible
Physician's Services	No charge	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.		
Physician's Office Visit	No charge after the $10 PCP or $10 Specialist per office visit copay	70% after plan deductible
Inpatient Facility	No charge	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible
Physician's Services	No charge	70% after plan deductible
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		
Mental Health		
Inpatient	No charge	70% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)		
Physician's Office Visit	$10 per visit copay	70% after plan deductible
Outpatient Facility	100%	70% after plan deductible
Substance Abuse		
Inpatient	No charge	70% after plan deductible
Outpatient (Includes Individual and Intensive Outpatient)		
Physician's Office Visit	$10 per visit copay	70% after plan deductible
Outpatient Facility	100%	70% after plan deductible

Point of Service Medical Benefits

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

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

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization by the end of the first scheduled work day after the admission or as soon as reasonably possible. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement. The results of that review will be communicated to you, the attending Physician and Cigna.

Covered Expenses incurred will be reduced by 50% for Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, by the end of the first scheduled work day after the date of admission. Notice provided after this deadline will be accepted and the penalty waived, provided notification was made as soon as reasonably possible.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will be reduced by 50%:

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

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

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

Outpatient Certification Requirements - Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedures. The results of the review will be communicated to you, the attending Physician and Cigna within 5 days of the Review Organization having received the request for certification. Outpatient Certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should only be requested for nonemergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will be reduced by 50% for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is requested prior to the date the testing or procedure is performed.

Covered Expenses incurred will be reduced by 50% for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

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

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

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

Prior Authorization/Pre-Authorized

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

Services that require Prior Authorization to certify Medical Necessity to be considered a Covered Expense include, but are not limited to:

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

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Covered Expenses

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

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for a baseline mammogram for women between the ages of 35 and 40; an annual mammogram for women age 40 and over; and mammograms at any time if ordered by a woman's health care provider for women with a family history of breast cancer or other breast cancer risk factors.
- charges made for an annual Papanicolaou laboratory screening test. Pap smear coverage includes an initial pap smear and any confirmatory tests, when Medically Necessary, as ordered by the attending Physician, including all associated laboratory tests.
- charges made for an annual prostate-specific antigen test (PSA), including a digital rectal examination, for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer, or other prostate cancer risk factors.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- abortion when a Physician certifies in writing that the pregnancy would endanger the life of the mother, or when the expenses are incurred to treat medical complications due to abortion.
- charges made for the following preventive care services (detailed information is available at www.healthcare.gov.):
  (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
  (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and

Prevention with respect to the Covered Person involved;

(3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

(4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

- charges made for Preventive Care consisting of the following health and wellness tests and services delivered or supervised by a Physician, in keeping with prevailing medical standards:
  - for all persons 20 years of age and older, annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, instead, low-density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level; for all persons 35 years of age or older, a glaucoma eye test every five years; for all persons 40 years of age or older, an annual stool examination for presence of blood; for all persons 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years; for all women 20 years of age and older; a Pap smear as recommended by a Physician; for all women 40 years and older, a mammogram annually; for all adults, recommended immunizations; and all persons 20 years of age and older, an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-exam and seat belt usage in motor vehicles; excluding any charges for:
    - services for which benefits are otherwise provided under this Medical Benefits section;
    - services for which benefits are not payable according to the Expenses Not Covered section.

  Other wellness tests and time schedules will be covered upon the recommendation of a Physician. Any In-Network deductible will be waived for these preventive care services.

  Additionally, Covered Expenses include charges for childhood immunizations as recommended by the Advisory Committee on Immunization practices of the U.S. Public Health Service, the Department of Health and the New Jersey Department of Health and Senior Services for a Dependent child during that child's lifetime. Any In-Network deductible will be waived for childhood immunizations.

- charges for the following screening examinations and laboratory tests for colorectal cancer screening in average-risk adults, beginning at age 50: annual guaiac-based fecal occult blood test (gFOBT) with high tests sensitivity for cancer; annual immunochemical-based fecal occult blood test (FIT) with high test sensitivity for cancer; stool DNA (sDNA) test with high test sensitivity for cancer; flexible sigmoidoscopy every five years; colonoscopy every ten years; double contract barium enema every five years; computed tomography colonography (virtual colonoscopy) every five years.
- charges for maternity benefits to include 48 hours of inpatient care following a vaginal delivery and 96 hours of inpatient care following a cesarean section for a mother and her newborn child in a licensed health care facility if requested by the mother or determined by the attending Physician to be Medically Necessary.
- charges for screening by blood lead measurement for lead poisoning for children, including: confirmatory blood lead testing, medical evaluation, and any necessary medical follow-up and treatment for lead poisoning for children.
- charges for therapeutic treatment of inherited metabolic diseases, when diagnosed by a Physician and deemed to be medically necessary. Treatment includes the purchase of medical foods and low protein modified food products. Inherited metabolic diseases means a disease caused by an inherited abnormality of body chemistry. A low protein modified food product is one that is specially formulated to have less than one gram of protein per serving. It is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease, but does not include a (natural) food that is naturally low in protein.

  Medical food means one that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Physician.
- charges for screening for newborn hearing loss by electrophysiologic screening measures and periodic monitoring. Any deductible will be waived for newborn and infant hearing screening.
- charges for or in connection with a drug that has been prescribed for a treatment for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be covered, provided: it is recognized as medically appropriate for that specific treatment in one of the following reference compendia: the American Medical Association Drug Evaluations; the American Hospital Formulary Service Drug Information; the United States Pharmacopeia Drug Information; or it is recommended by a clinical study or review article in a major peer-reviewed

professional journal; and the drug has not been contraindicated by the FDA for the use prescribed.

- charges for insulin, insulin syringes, prefilled insulin cartridges for the blind, glucose test strips, visual reading strips and urine test strips, lancets, alcohol swabs and oral blood sugar control agents which are recommended or prescribed by a Physician, nurse practitioner or clinical nurse specialist for the treatment of diabetes. Diabetic pharmaceuticals are payable at the same Deductible and Coinsurance as any other Covered Expense.
- charges for blood glucose monitors (including monitors for the blind), insulin pumps, infusion devices and related accessories. Charges for these items are not subject to the Durable Medical Equipment Maximum shown in The Schedule.
- charges for the diagnosis and treatment of autism and other developmental disabilities.

  For a primary diagnosis of autism or another developmental disability, Cigna provides coverage for the following medically necessary therapies as prescribed through a treatment plan:

  - occupational therapy where occupational therapy refers to treatment to develop a covered person's ability to perform the ordinary tasks of daily living;
  - physical therapy where physical therapy refers to treatment to develop a covered person's physical function; and
  - speech therapy where speech therapy speech therapy refers to treatment of a speech impairment.

  If a covered person's primary diagnosis is autism, and the covered person is under 21 years of age, in addition to coverage for the therapy services as described above, Cigna also covers Medically Necessary behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs as prescribed through a treatment plan. Except as stated below, such coverage of medically necessary behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs is subject to a $36,000 maximum benefit per calendar year for each year through 2011. (Thereafter the maximum benefit shall be adjusted by New Jersey regulation.)

  NOTE: ANY SUCH BEHAVIORAL INTERVENTION BENEFITS A COVERED PERSON RECEIVES AS AN OUT-OF-NETWORK COVERED CHARGE WILL REDUCE THE SERVICES AVAILABLE AS IN-NETWORK BEHAVIORAL INTERVENTION SERVICES.

  Exception: If the Employer providing coverage under the Contract is subject to the Federal law governing parity in mental health and substance use disorder benefits the maximum benefit does not apply.

  The treatment plan(s) referred to above must be in writing, signed by the treating physician, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. Cigna may request additional information if necessary to determine the coverage under this plan. Cigna may require the submission of an updated treatment plan once every six months unless Cigna and the treating physician agree to more frequent updates.
- charges made for surgical or nonsurgical treatment of Temporomandibular Joint Dysfunction.

Clinical Trials

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

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

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

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

Genetic Testing

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

- a person has symptoms or signs of a genetically-linked inheritable disease;

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

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

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

Nutritional Evaluation

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

Internal Prosthetic/Medical Appliances

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

Diabetic Services

Charges made for diabetic services, provided an official diagnosis of diabetes has been made by a Physician. Diabetic services include:

- coverage for an annual screening via dilated eye examinations by a Physician for person with diabetes;
- glycohemoglobin A1c blood testing determination whenever needed to assess and achieve near-normal glycemia; and
- microalbumin/urinalysis screening annually.

Additional diabetic services include:

- coverage for Medically Necessary fitting of therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices and shoe modifications;
- calluses and nail trimming;
- complex evaluation of sensory loss; and
- treatment of ulcerations with total contact casting.

Diabetic services will also include inpatient and outpatient self-management training services provided by a Physician, by a certified diabetes educator, or by a registered pharmacist qualified to provide management education for diabetes:

- according to standards established under New Jersey Department of Health and Senior Services regulations upon diagnosis of diabetes; or
- when a Physician certifies that a change in self-management is needed due to a change in symptoms or conditions, or that new medication, therapy or retraining is Medically Necessary.

Covered training will also include nutrition therapy by a licensed, certified dietician or nutritionist and must be supervised and certified as completed successfully by a Physician.

Second Surgical Opinion Benefits

Covered Expenses will include expenses incurred for charges made for a second surgical opinion if, as a result of an Injury or a Sickness, you or any one of your Dependents, while insured for these benefits and prior to the performance of an Elective Surgical Procedure recommended by a surgeon, asks for an opinion from another Physician who is qualified to diagnose and treat that Injury or Sickness. Covered Expenses will also include any diagnostic laboratory or x-ray examinations asked for by the Physician who gives that opinion.

Payment will be made whether or not the Surgical Procedure is performed.

Third Surgical Opinion Benefits

If your second surgical opinion does not confirm that an Elective Surgical Procedure is medically advisable, a third surgical opinion will also be covered.

Limitations

No payment will be made for expenses incurred in connection with:

- cosmetic or dental Surgical Procedures not covered under the policy;
- minor Surgical Procedures that are routinely performed in a Physician's office, such as incision and drainage for abscess or excision of benign lesions;
- an opinion rendered by the Physician who performs the Surgical Procedure.
- other limitations shown in the General Limitations section.

No payment will be made under any other section to the extent that benefits are payable for incurred expenses under this section.

Elective Surgical Procedure

The term Elective Surgical Procedure means a Surgical Procedure which is not considered emergency in nature and which may be avoided without undue risk to the individual.

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Orthognathic Surgery

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

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

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Home Health Services

- charges made for Home Health Services under the terms of a Home Health Care Plan established within 14 days after the date Home Health Care begins.

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

  Home Health Services include:

  - part-time or intermittent services, and full-time or 24-hour services that are needed on a short-term basis, including nursing care by or under the supervision of an Other Health Care Professional;
  - physical, occupational or speech therapy;
  - medical social work;
  - nutrition services;
  - medical supplies, appliances and equipment; drugs and medicines lawfully dispensed only on the written prescription of a Physician; laboratory services; special meals, home infusion therapy and any diagnostic and therapeutic service, including surgical services, performed in a Hospital outpatient department, a doctor's office or any other licensed health facility; but only to the extent that such charges would have been considered Covered Expenses had a person required confinement in the Hospital as a registered bed patient or confinement in a Skilled Nursing Facility.

  Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional.

  Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are subject to the Home Health Services benefit limitations in the Schedule.

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Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;

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

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

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

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Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat any mental disorder other than Biologically-Based Mental Illness, or other than a disease induced by Substance Abuse, that impairs the behavior, emotional reaction or thought processes of a person, regardless of medical origin. Services for Biologically-Based Mental Illness are specifically excluded hereunder because these services are provided :as an other illness" as part of Medical Benefits coverage. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

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

Inpatient Mental Health Services

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

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

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

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

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

Outpatient Mental Health Services

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

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

Inpatient Substance Abuse Rehabilitation Services

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

Services for the treatment of alcoholism will be rendered under the "same terms and conditions" as any other illness under your plan when such treatment is prescribed by a Physician.

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

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

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

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

Outpatient Substance Abuse Rehabilitation Services

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

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

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol will be provided under the "same terms and conditions" as any other illness under the plan. Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

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

- any Mental Health services in connection with Biologically-Based Mental Illness.
- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Mental Health Services for Biologically-Based Mental Illness

If you or any one of your Dependents, while insured for these benefits, incurs expenses for charges made for Medically Necessary Mental Health Services for Biologically-Based Mental Illness, Cigna will pay that portion of the expense remaining after you or your Dependent has paid any required Deductible or Coinsurance shown in the Schedule.

These benefits for Biologically-Based Mental Illness will be provided under the same terms and conditions as provided "for any other sickness" under the policy.

Same Terms and Conditions means that Cigna will not apply different copayments, deductibles or benefit limits to biologically-based mental health benefits than those applied to other medical or surgical benefits.

The term **Biologically-Based Mental Illness** means a mental or nervous condition that is caused by a biological disorder of the brain which results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to:

- schizophrenia;
- schizoaffective disorder;
- major depressive disorder;
- bipolar disorder;
- paranoia and other psychotic disorders;
- obsessive-compulsive disorder;
- panic disorder;
- pervasive developmental disorder; or
- autism.

Durable Medical Equipment

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

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

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

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

External Prosthetic Appliances and Devices

- charges made for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription from a licensed orthotist, prosthetist, or certified pedorthist, which are determined medically necessary by the covered person's Physician for the alleviation or correction of Injury, Sickness or congenital defect.

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

Prostheses/Prosthetic Appliances and Devices

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

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

Orthoses and Orthotic Devices

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

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

The following are specifically excluded orthoses and orthotic devices:

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

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

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

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - no more than once every 24 months for persons 19 years of age and older;
  - no more than once every 12 months for persons 18 years of age and under; and
  - replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs (including injectable infertility medications); approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy (including microsurgical sperm aspiration); laboratory tests; sperm washing or preparation; diagnostic evaluations; assisted hatching; ovulation induction; gamete intrafallopian transfer (GIFT); and the services of an embryologist.

However, the following are specifically excluded infertility services:

- reversal of male and female voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;

- donor charges and services, except if Medically Necessary to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid;
- cryopreservation of donor sperm and eggs; and
- any experimental, investigational or unproven infertility procedures or therapies.
- in vitro fertilization (IVF), including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate;
- fresh and frozen embryo transfer;
- artificial insemination;
- intracytoplasmic sperm injection (ICSI);
- zygote intrafallopian transfer (ZIFT).

Infertility services are covered for any abnormal function of the reproductive systems, such that you are not able to:

- impregnate another person;
- conceive after two years if the female partner is under 35 years old, or after one year if the female partner is 35 years old or older, or if one partner is considered medically sterile; or
- carry a pregnancy to live birth.

In vitro fertilization, gamete transfer and zygote transfer services are covered only:

- if you have used all reasonable, less expensive and medically appropriate treatment and are still unable to become pregnant or carry a pregnancy;
- up to four completed egg retrievals combined, per lifetime (including those covered under prior plans, but not those provided at your expense); and
- if you are 45 years old or younger.

Short-Term Rehabilitative Therapy

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

The following limitation applies to Short-term Rehabilitative Therapy:

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

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

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

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

A separate Copayment will apply to the services provided by each provider.

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

Chiropractic Care Services

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

You do not need a referral from your Primary Care Physician.

The following limitation applies to Chiropractic Care Services:

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

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;

- vitamin therapy.

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Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

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

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Transplant Services

- charges made for human organ and tissue Transplant services which 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, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

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

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

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

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

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of a military, non-combatant civilian, or civilian illness or injury which is due to war, declared or undeclared. Military exclusions exclude treatment of an illness or injury suffered: as a result of war or an act of war, if the illness or injury occurs while the insured person is serving in the military, naval or air forces of any country, combination of countries or international organization; and as a result of the special hazards incident to service in any civilian non-combatant unit supporting or accompanying such forces, provided the illness or injury occurs while the insured person is serving in such unit and is outside the 50 United States of America, Puerto Rico, U.S. Virgin Islands, the District of Columbia or Canada.

  Civilian exclusions exclude treatment of illness or injury suffered as a result of war or an act of war while the covered person is not in the military, naval or air forces of any country, combination of countries or international organization or in any civilian non-combatant unit supporting or accompanying such forces, if the illness or injury occurs outside the 50 United States of America, Puerto Rico, U.S. Virgin Islands, the District of Columbia or Canada.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services, except for bone marrow transplants as treatment for Wilms' tumor and except for drugs not recognized for the treatment if the particular indication in standard reference compendia or in medical literature.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance. This exclusion does not apply to the necessary care and treatment of a Dependent child from the moment of birth with a medically diagnosed congenital defect or birth abnormality.
- The following services are excluded from coverage regardless of clinical indications:Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid)

obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school (an educational program to help prevent injury to the spine), return to work services, work hardening programs (a series of exercises that injured workers perform as part of a rehabilitation program), driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation (except as may be provided for in "Covered Expenses").
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Diabetic Services," "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound. This exclusion does not apply to coverage for hearing aids for Dependent children 15 years of age or younger.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- treatment by acupuncture.
- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- nutritional supplements and formulae except as provided for in "Covered Expenses."
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.
- abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.
- Tubal ligation and and vasectomies.

General Limitations

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

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

Personal Injury Protection (PIP) or Out-of-State Automobile Insurance Coverage (OSAIC)

When expenses are incurred as the result of an Automobile Related Injury, and the injured person has coverage under Personal Injury Protection (PIP) or Out-of-State Automobile Insurance Coverage (OSAIC), this section will be used to determine whether this certificate provides coverage that is primary to such coverage or secondary to such coverage. It will also be used to determine the amount payable if this certificate provides primary or secondary coverage.

This certificate provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the person covered under this policy. This election is made by the named insured under a PIP policy and affects that person's family members who are not themselves named insureds under another automobile certificate. This certificate may be primary for one covered person, but not for another if the persons have separate automobile insurance policies and have made different selections regarding primacy of health coverage.

This certificate is secondary to OSAIC. However, if the OSAIC contains provisions which make it secondary or excess to the policyholder's Plan, then the policyholder's Plan is primary.

If there is a dispute as to whether this plan is primary or secondary, this certificate will pay benefits as if it were primary.

If this plan is primary to PIP or OSAIC, this certificate will pay benefits payable on eligible expenses in accordance with the terms provided in this certificate.

If this plan is one of several insurance plans which provide benefits to the insured and are primary to automobile insurance coverage, then the rules as provided in the Coordination of Benefits section of this certificate shall apply.

If this plan is secondary to PIP, the actual benefits payable will be the lesser of: the remaining uncovered allowable expenses after PIP has provided coverage after application of deductibles and copayments, or the actual benefits that would have been payable had the plan been providing coverage primary to PIP.

To the extent that the certificate provides coverage that supplements coverage under Medicare, then the plan can be primary to automobile insurance only insofar as Medicare is primary to automobile insurance.

Coordination of Benefits

PLEASE NOTE: If you are covered by more than one health benefit plan, you should file all your claims with each plan and provide each plan with information regarding the other plans under which you are covered.

Purpose of This Provision

A covered person may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows Cigna to coordinate what Cigna pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the primary plan and which is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the covered person is covered.

Definitions

The words shown below have special meanings when used in this provision. Please read these definitions carefully. Throughout this provision, these defined terms appear with their initial letter capitalized.

Allowable Expense: The charge for any health care service, supply or other item of expense for which the covered person is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this policy is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

Cigna will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.

When this policy is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, Cigna will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period: A Calendar Year, or any portion of a Calendar Year, during which a covered person is covered by this policy and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

- Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
- Group hospital indemnity benefit amounts that exceed $150.00 per day;
- Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:

- Individual or family insurance contracts or subscriber contracts;
- Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
- Group or group-type coverage where the cost of coverage is paid solely by the covered person except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
- Group hospital indemnity benefit amounts of $150.00 per day or less;
- School accident-type coverage;
- A State plan under Medicaid.

Primary Plan: A Plan whose benefits for a covered person's health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either item below exists:

- The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
- All Plans which cover the covered person use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply as determined by Cigna, based on a standard which is most often

charged for a given service by a Provider within the same geographic area.

Secondary Plan: A Plan which is not a Primary Plan. If a covered person is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

Primary and Secondary Plan

Cigna considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each claim determination period the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "Procedures to be Followed by the Secondary Plan to Calculate Benefits" section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Rules for the Order of Benefit Determination

The benefits of the Plan that covers the covered person as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the covered person as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the covered person as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the covered person as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the covered person as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the covered person under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

- The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
- If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the plan which covered the other parent for a shorter period of time.
- "Birthday," as used above, refers only to month and day in a Calendar Year, not the year in which the parent was born.
- If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

- The benefits of the Plan of the parent with custody of the child shall be determined first.
- The benefits of the Plan of the spouse of the parent with custody shall be determined second.
- The benefits of the Plan of the parent without custody shall be determined last.
- If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:

- The basis on which the Primary Plan and the Secondary Plan pay benefits; and
- Whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R & C), or some similar term. This means that the provider bills a charge and the covered person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R & C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the covered person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the covered person uses the services of a non-network provider, the plan will be treated as an R & C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation." This means that the HMO or other plan pays the provider a fixed amount per covered person. The covered person is liable only for the applicable deductible, coinsurance or copayment. If the covered person uses the services of a non-network provider, the HMO or other plan will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is R & C Plan and Secondary Plan is R & C Plan

The Secondary Plan shall pay the lesser of:

- The difference between the amount of the billed charges and the amount paid by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and the covered person shall not exceed the fee schedule of the Primary Plan. In no event shall the covered person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is R & C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

- The difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

The covered person shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the covered person has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall the covered person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R & C Plan

If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R & C Plan or Fee Schedule Plan

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the covered person receives from a non-network provider is not considered

as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R & C Plan

If the covered person receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

- The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R & C Plan and Secondary Plan is Capitation Plan

If the covered person receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The covered person shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

Primary Plan is an HMO and Secondary Plan is an HMO

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the covered person receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan, except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

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Medicare Eligibles

Cigna will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

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

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

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

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

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

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

Cigna will assume the amount payable under:

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

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

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

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Payment of Benefits

To Whom Payable

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

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

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal

guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

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

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

Time of Payment

Benefits will be paid by Cigna within 30 days after it receives a proper claim by electronic means and within 40 days after it receives a proper claim by other than electronic means. A claim will be considered to be properly submitted if it is an eligible claim for a health care service provided by a Physician to an insured; the claim has no material defect such as missing substantiating documentation or incorrect coding; there is no dispute regarding the amount of the claim; Cigna has no reason to believe the claim is fraudulent; and the claim requires no special treatment that prevents timely payment. If the claim is in whole or in part denied, ineligible, incomplete of substantiating documentation, miscoded or contains misinformation, the amount is in dispute, or requires special treatment, Cigna will in writing or by electronic means as appropriate, give an explanation of: denial, what documentation is needed to perfect a claim, a disputed claim amount, or a claim requiring extra time to process. Cigna will give notice of receipt of a claim by electronic means no later than two working days following receipt of the transmission of the claim. An overdue payment shall bear simple interest at the rate of 12% per annum.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right, as permitted by New Jersey law, to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology,
- the methodologies as reported by generally recognized professionals or publications.

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Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

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

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

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: stops paying premium for you; or otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

Dependents

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

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

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

Dependent Medical Insurance After Your Death

If you are insured for Medical Insurance when you die, any of your Dependents who are then insured for such insurance, will remain so insured, provided that premiums are paid until the earliest of the following date:

- the 180th day after your death;

- if a surviving spouse remarries, the date he remarries or the 180th day after your death, whichever is later;
- if a Dependent becomes eligible for Medicare, the date he becomes eligible or the 180th day after your death, whichever is later;
- the date Dependent ceases to pay any required premiums for the insurance;
- the date that Dependent ceases to qualify as a Dependent for a reason other than lack of primary support by you.

The Dependent benefits payable after you die will be those in effect for your Dependents on the day prior to your death.

Continuation

Special Continuation of Medical Insurance – Total Disability

If your insurance would otherwise cease due to total disability, and if you have been insured for at least three consecutive months under the policy, and if you pay your Employer the required premium, your Medical Insurance will be continued until the earliest of:

- the last day for which you have paid the required premium;
- the date you become employed and eligible for similar insurance under another group policy for medical and dental benefits;
- the date the policy is canceled.

Within 31 days after the date the insurance would otherwise cease, you may elect such continuation by completing a continuation notification and by paying the required premium to your Employer.

If your insurance is being continued as outlined above, the Medical Insurance for any of your Dependents insured on the date your insurance would otherwise cease may be continued, subject to the above provisions. The Dependent Medical Insurance will be continued until the earlier of:

- the date your insurance ceases; or
- with respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent.

This option will not operate to reduce any continuation of insurance otherwise provided.

Continuation of Coverage for Dependent Children under New Jersey Law

A Dependent child of a Covered Person who meets the limiting age for coverage of a Dependent, is eligible to continue coverage for himself until his 31st birthday, provided he meets all of the following "Special Eligibility Criteria" for this continuation coverage:

- is a Covered Person's child by blood or by law; and
- has reached the limiting age as specified under his parents' policy, but has not yet reached his 31st birthday; and
- is unmarried; and
- has no Dependents of his own; and
- is either a resident of New Jersey OR is enrolled as a full-time student at an accredited public or private institution of higher education; and
- is not covered under any other group or individual health benefits plan, and is not entitled to benefits under Medicare.

To obtain continued coverage under this provision, the Dependent child must make a written election for continuation coverage as a Dependent, complete any necessary enrollment forms and pay the premium, at any of the following times:

- within 30 days prior to the termination of coverage at the specific age provided in this Plan; or
- within 30 days after meeting the "Special Eligibility Criteria" requirements, when coverage for the Dependent under this Plan previously terminated; or
- during an open enrollment period, if provided in the Plan, if the Dependent child meets the "Special Eligibility Criteria" during the open enrollment period; or
- for the initial 12 months after the effective date of this legislation, from 5/12/2006 to 5/11/2007 only, a Dependent child meeting the "Special Eligibility Criteria" whose coverage as a Dependent under a Covered Person's policy terminated prior to 5/12/2006 due to attainment of limiting age under such Covered Person's policy.

A Dependent child is only entitled to make an election for continued coverage if the Dependent child was actually covered under his parent's Plan on the date he reached the limiting age and was terminated due to reaching such limiting age.

To continue group health benefits, the Dependent child must meet all of the requirements specified in this section and must make written election to us. The effective date of the Dependent child's continued coverage will be the later of: the date the Dependent child requests continued coverage with us; or the date the Dependent meets all of the "Special Eligibility Criteria." This continued coverage is conditional upon the Dependent child completing the required enrollment form and sending us the first month's premium due. The Dependent child covered under this continuation benefit must pay subsequent premiums monthly, in advance, at the times and in the manner specified by us. Premium payments, other than the first premium payment, will be considered timely if payment

is made no later than 30 days of the date such premium payment is due.

For a Dependent child whose coverage has not yet terminated due to the attainment of the limiting age as specified under this Plan, the written election must be made within 30 days prior to termination of coverage due to the attainment of the limiting age.

For a Dependent child who did not qualify for this continued coverage because he fails to meet all the "Special Eligibility Criteria," but who subsequently meets all of the "Special Eligibility Criteria," written election must be made within 30 days after the Dependent child first subsequently meets all of the requirements.

This election opportunity for the Dependent child is explained in greater detail as follows:

- If a Dependent child did not qualify because he or she was married, the notice must be given within 30 days of the date he or she is no longer married.
- If a Dependent child did not qualify because he had a Dependent of his own, the election must be made within 30 days of the date he no longer has a Dependent.
- If a Dependent child did not qualify because he either was not a resident of New Jersey or was not a full-time student at an accredited school, the election must be made within 30 days of the date he becomes a resident of New Jersey, or becomes a full-time student at an accredited school.
- If a Dependent child did not qualify because he was covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or was entitled to Medicare, the election must be made within 30 days of the date he is no longer covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or is no longer entitled to Medicare.

Each year, there will be an Open Enrollment Period as specified under this Plan during which a Dependent child who previously did not elect to continue coverage, may make an election to continue coverage.

A Dependent child who qualifies for this continuation coverage as of May 12, 2006, having reached the limiting age under his parents' plan and lost coverage prior to May 12, 2006 due to reaching such limiting age, may give written notice of an election for continued coverage at any time beginning May 12, 2006 and continuing until May 11, 2007.

A Dependent child who was covered under prior Creditable Coverage that terminated no more than 90 days prior to making an election for continuation under this section will be given credit for the time he was covered under the Creditable Coverage toward the application of the Pre-Existing Conditions Exclusion under the Policy.

The continued coverage shall be identical to the coverage provided to the Dependent child continuant's parent who is covered as an Employee under this Plan. If coverage is modified for Dependents who are under the limiting age as specified in this Plan, the coverage for Dependent child continuants shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

The Group is required to notify the Dependent child in writing of the option to continue coverage and the duties of continuing coverage at the following times:

- on/before the coverage of the Dependent terminates due to reaching the limiting age; and
- at the time coverage terminates because the Dependent child no longer meets the "Special Eligibility Criteria", except that notice is not required when the Dependent child turns 30 or has a dependent of his own; and
- before any open enrollment period; and
- immediately following 5/12/2006, for the subsequent 12 months.

Continuation of coverage under this section will end on the earliest of the following dates:

- the date ending the period for which premium has been paid for the Dependent child continuant, subject to the Grace Period for such payment; or
- the date the Group ceases to provide coverage to the Covered Person, who is the Dependent child's parent; or
- the date the Plan under which the Dependent child continuing coverage is amended to delete coverage for Dependents; or
- the date the Dependent child ceases to continue to meet any of the "Special Eligibility Criteria" requirements; or
- the date the Dependent child's parent who is covered as an Employee under this Plan waives Dependent coverage. Except, if the Employee has no other Dependents, the Dependent child continuant's coverage will not end as a result of the Employee waiving Dependent coverage.

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Rescissions

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

person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

HC-TRM80 01-11

Medical Benefits Extension Upon Policy Cancellation

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

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group policy;
- the date you are no longer Totally Disabled (but only if benefits for that disabling condition are being paid for you under the replacing policy);
- 12 months from the date your Medical Benefits cease; or
- 12 months from the date the policy is canceled.

Totally Disabled

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

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

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

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

Please Note: The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when you or your Dependent's Medical Benefits cease.

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Federal Requirements

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

HC-FED1 10-10

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

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

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

HC-FED2 10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

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

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

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

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

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

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

- the other plan no longer offers any benefits to a class of similarly situated individuals.

- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

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

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

Effect of Section 125 Tax Regulations on This Plan

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

A. Coverage Elections

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

- the date you meet the criteria shown in the following Sections B through H.

B. Change of Status

A change in status is defined as:

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

C. Court Order

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

D. Medicare or Medicaid Eligibility/Entitlement

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

E. Change in Cost of Coverage

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

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

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

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

G. Reduction in work hours

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

H. Enrollment in Qualified Health Plan (QHP)

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

HC-FED70 12-14

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.

HC-FED67 09-14

Coverage for Maternity Hospital Stay

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

Please review this Plan for further details on the specific coverage available to you and your Dependents.

HC-FED11 10-10

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.

HC-FED12 10-10

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.

HC-FED13 10-10

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

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

Continuation of Health Insurance During Leave

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

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

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

Reinstatement of Canceled Insurance Following Leave

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

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

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

HC-FED17 10-10

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.

Continuation of Coverage

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

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

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

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

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

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

Reinstatement of Benefits (applicable to all coverages)

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

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

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

HC-FED18 10-10

Claim Determination Procedures under ERISA

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

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.

Medical Necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below:

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

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

Preservice Medical Necessity Determinations

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

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's Physician reviewer, in consultation with the treating Physician, 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 fails to follow Cigna's procedures for requesting a required preservice Medical Necessity determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Medical Necessity Determinations

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

Postservice Medical Necessity Determinations

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

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

Postservice Claim Determinations

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

within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

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

HC-FED40 04-12

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.

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

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

Who is Entitled to COBRA Continuation?

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

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

Secondary Qualifying Events

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

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or

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

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

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

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

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

Medicare Extension for Your Dependents

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

Termination of COBRA Continuation

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

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

Moving Out of Employer's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer's service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

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

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation

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

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. 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.

HC-FED66 07-14

Clinical Trials

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

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

(b) either

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

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

The clinical trial must meet the following requirements:

The study or investigation must:

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

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

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

Routine patient care costs do not include:

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

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

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

HC-FED53 10-13

ERISA Required Information

The name of the Plan is:

Seton Hall University Welfare Benefits Program

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

Seton Hall University
400 South Orange Avenue
South Orange, NJ 07079
973-761-9177

Employer Identification Number (EIN):	Plan Number:
221500645	505

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

Employer named above

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

Employer named above

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

The Cigna Claim Office responsible for this Plan

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

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

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

Plan 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 this summary plan description and 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 plan documents 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.

HC-FED68 08-14

Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

HC-SPP4 04-10
V1

When You Have A Concern Or Complaint

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted and a "Physician reviewer" is a licensed Physician who is also a Medical Director or his or her designee who rendered the initial adverse determination.

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.

Complaints and Administrative Appeals Regarding Contractual Benefits, Quality of Care and Services

Start with Member Services

We are here to listen and help. If you have a specific concern or complaint regarding a person, a service, the quality of care, choice of or access to providers, provider network adequacy or contractual benefits, you or your designated representative (including your treating Provider) can call our toll-free number and explain your concern to one of our Customer

Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 calendar days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Administrative Appeals Procedure

Cigna has a two step appeals procedure for coverage decisions. To initiate an Administrative appeal, you must submit a request for an appeal in writing within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by calling the toll-free number on your Benefit Identification card. If you choose to designate a representative to appeal on your behalf, including your provider, all correspondence related to your appeal will be sent to your designated representative and you. If you do not want such representative to pursue the appeal on your behalf, you must notify Cigna that you do not want this representative appealing this issue on your behalf.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Expedited appeals will be considered by a health care professional.

For level one appeals, we will acknowledge in writing that we have received your request within 10 business days and respond in writing with a decision within 30 calendar days after we receive an appeal for a post-service coverage determination or within 15 calendar days for a pre-service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond with a decision within 72 hours.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal, except that such a request must be submitted within 60 days from your receipt of a Level One Appeal decision.

Receipt of requests for a second review will be acknowledged in writing within 10 business days. Post-service requests will be completed within 30 calendar days, while most pre-service requests will be completed within 15 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. You will be notified in writing of the decision.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond with a decision within 72 hours.

Appeal to the State of New Jersey

For appeals regarding a person, a service, the quality of care, choice of or access to providers, provider network adequacy, or the contractual benefits, if you remain dissatisfied after exhausting Cigna's Complaint and Appeal procedure, you may appeal to the State of New Jersey Department of Banking and Insurance at the following address and telephone number:

Consumer Protection Services
New Jersey Department of Banking and Insurance
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
(609) 292-5316

You may also wish to access an online New Jersey complaint form at: www.state.nj.us/dobi/enfcon.htm.

Appeals Regarding Required Medical Necessity and Utilization Review Determinations

Initial Determination

Cigna is responsible for making decisions about the appropriateness, medical necessity and efficiency of health care services provided to Members under this Certificate. All decisions to deny or limit coverage for an inpatient admission, a service, a procedure or an extension of inpatient stay, are made by a New Jersey-licensed Physician.

The health care determinations made by Cigna are directly communicated to the treating or requesting Provider (including a Provider acting on your behalf with your consent, if such Provider is the requesting Provider) on a timely basis appropriate to the Member's medical needs. Cigna will not reverse its initial determination of medical necessity or appropriateness unless misrepresented or fraudulent information was submitted to Cigna as part of the request for health care services.

You or your designated representative (including a provider acting on your behalf with your consent) may request a written notice of an initial determination made by Cigna, including an explanation of the Medical Necessity Appeal process.

Medical Necessity Appeals Procedure

Cigna has a two step procedure for coverage decisions. To initiate a Medical Necessity appeal, you must submit a request for an appeal in writing to the address that appears on your Benefit Identification card, explanation of benefits or claim form within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by calling the toll-free number on your Benefit Identification card. If you choose to designate a representative to appeal on your behalf, including your provider, all correspondence related to your appeal will be sent to your designated representative and you. If you do not want such representative to pursue the appeal on your behalf, you must notify Cigna that you do not want this representative appealing this issue on your behalf.

Level One Appeal

You have the opportunity to speak with, and may request appeal review by, Cigna's Physician reviewer.

For level one appeals, we will respond in writing with a decision within five business days after we receive an appeal.

You may request that the appeal process be expedited if: the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; your appeal involves non-authorization of an admission or continuing inpatient Hospital stay; or your appeal addresses a determination regarding urgent or emergency care. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond with a decision within 72 hours.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal, except that such a request must be submitted within 60 days from your receipt of a Level One Appeal decision.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least one Physician reviewer and two other Physicians/health care professionals. Anyone involved in the prior decision may not participate on the Appeal Committee. The committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may request that the same or similar specialist be a participant on the committee. You may present your situation to the committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request within 10 business days and schedule a committee review. The committee review will be completed within 15 calendar days for pre-service appeals and 20 business days for post-service appeals. If more time or information is needed to make the determination, we will notify the Department of Banking and Insurance and you in writing to request an extension of up to 15 calendar days for pre-service appeals and 20 business days for post-service appeals and to specify any additional information needed by the Appeals Committee to complete the review. You will be notified in writing of the Appeals Committee's decision.

You may request that the appeal process be expedited if: the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; your appeal involves non-authorization of an admission or continuing inpatient Hospital stay; or your appeal addresses a determination regarding urgent or emergency care. When an appeal is expedited, we will respond with a decision within 72 hours.

External Appeals of Utilization Management Determinations

After exhausting Cigna's Medical Necessity Appeal procedure, if you remain dissatisfied with Cigna's health care determination, you may initiate a review by an Independent Utilization Review Organization (IURO) within 60 calendar days from the receipt of Cigna's final written decision. To initiate a review, you or your Provider, on your behalf, should complete the State of New Jersey IURO forms provided by Cigna and mail the completed forms to:

Consumer Protection Services
New Jersey Department of Banking and Insurance
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
(609) 292-5316

along with a check or money order for $25 payable to the "New Jersey Department of Banking and Insurance" (this fee may be reduced to $2 in cases of financial hardship). If a Provider is appealing to the IURO on your behalf, the Provider is responsible for paying your portion of the cost of the IURO appeal (e.g. $25, or $2 if financial hardship). Cigna will bear the remaining costs of the review.

You or your Provider, on your behalf, may also request review of your appeal by the IURO if Cigna has missed any timeframes associated with the processing of your medical necessity appeal. If this is the case, you must certify to the IURO that you or your Provider, on your behalf, did not hinder Cigna from making a timely determination by failing to provide the information required for Cigna to make its decision.

Once the IURO communicates its decision, Cigna will respond within 10 business days to you (or the Provider, on your behalf) the IURO and the Department of Banking and Insurance with a written report describing how Cigna will implement the IURO's decision.

The External Appeals Program is a voluntary program. The decision of the IURO is binding on Cigna.

Appeal to the State of New Jersey

You have the right to contact the New Jersey Department of Banking and Insurance for assistance at any time. The New Jersey Department of Banking and Insurance may be contacted at the following address and telephone number:

Consumer Protection Services
New Jersey Department of Banking and Insurance
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
(609) 292-5316

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include:

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined;
- a statement describing:
  - the procedure to initiate the next level of appeal;
  - any voluntary appeal procedures offered by the plan; and
  - the claimant's right to bring an action under ERISA section 502(a);
  - upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the Level Two Appeal decision (or with the Level One Appeal decision if expedited). You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which: was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action Following Appeals

If your plan is governed by ERISA, you have the right to bring a civil action in federal court under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action in federal court.

If your plan is governed by New Jersey P.L.2001, c.187 (2A:53A-30 et seq), you have the right to bring action in state court accordance with that statute. You must exhaust the Independent Health Care Appeals Program procedures created pursuant to section 11 of P.L.1997, c.192 (C26:2S-11), before filing an action in state court, unless serious or significant harm to the covered person has occurred or will imminently occur, before filing an action in state court for economic and non-economic loss that occurs as a result of Cigna's negligence with respect to the denial of or delay in approving or providing medically necessary covered services, which denial or delay is the proximate cause of a covered person's: death; serious and protracted or permanent impairment of a

bodily function or system; loss of a body organ necessary for normal bodily function; loss of a body member; exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment; a physical condition resulting in chronic and significant pain; or substantial physical or mental harm which resulted in further substantial medical treatment made medically necessary by the denial or delay of care.

HC-APL26 04-10
V1

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1 04-10
V1

Bed and Board

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

HC-DFS2 04-10
V2

Biologically-Based Mental Illness

A mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; and pervasive developmental disorder or autism.

HC-DFS110 4-10
V1

Charges

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

(When Related to Chiropractic Services)

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount with either the provider or a third party or arranger of services, in which case "charges" means the agreed upon rates that Cigna utilizes to directly pay the provider or third party. "Charges" does not mean the amount that a third party provider or arranger of services pays to a provider.

HC-DFS3 04-10
V2
HC-DFS502

Chiropractic Care

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

HC-DFS55 04-10
V1

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly

to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

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

HC-DFS4 04-10
V1

Dependent

Dependents are:

- your lawful spouse or civil union partner; and
- any child of yours who is:
  - less than 26 years old.
  - 26 or more years old, not married nor in a civil union partnership nor in a Domestic Partnership, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

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

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild. If your civil union partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

HC-DFS119 04-10
V1

Emergency Services

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of such Injury or Sickness are conditions that produce loss of consciousness or excessive bleeding, as well as conditions which may otherwise be determined by Cigna, in accordance with generally accepted medical standards, to require immediate medical attention The presenting symptoms, as coded by the provider and recorded by the Hospital on the claim form, or the final diagnosis, will be the basis for the determination of coverage.

HC-DFS111 04-10
V1

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 25 hours a week for the Employer.

HC-DFS7 04-10
V3

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

Essential Health Benefits

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

HC-DFS411 01-11

Expense Incurred

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

HC-DFS10 04-10
V1

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

HC-DFS11 04-10
V1

Hospice Care Program

The term Hospice Care Program means:

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

HC-DFS51 04-10
V1

Hospice Care Services

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

HC-DFS52 04-10
V1

Hospice Facility

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

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

HC-DFS53 04-10
V1

Hospital

The term Hospital means:

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

accordance with the laws of the appropriate legally authorized agency; or

- a public or private hospital or detoxification facility licensed by the state to provide treatment for alcoholism or a licensed residential treatment facility which provides an alcoholic treatment program which meets minimum standards of such care prescribed by the Joint Commission on the Accreditation of Healthcare Organizations.

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

HC-DFS115 04-10
V1

Hospital Confinement or Confined in a Hospital

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

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving emergency care in a Hospital for: an Injury, on his first visit as an outpatient within 72 hours after the Injury is received; or a sudden and unexpected Sickness within 12 hours after the Sickness begins, if lack of such care would cause his condition to worsen seriously;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

HC-DFS116 04-10
V1

In-Network/Out-of-Network

The term In-Network refers to healthcare services or items provided by your Primary Care Physician or services/items provided by another Participating Provider and authorized by your Primary Care Physician or the Review Organization. Authorization by your Primary Care Physician or the Review Organization is not required in the case of Mental Health and Substance Abuse treatment, other than Hospital Confinement solely for detoxification.

The term Out-of-Network refers to care which does not qualify as In-Network.

Emergency Care which meets the definition of Emergency Services and is authorized as such by either the Primary Care Physician or the Review Organization is considered In-Network. (For details, refer to the Emergency Services and Urgent Care coverage section.)

HC-DFS37 04-10
V1

Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

Maximum Reimbursable Charge - Medical

The Maximum Reimbursable Charge for Mental Health and Substance Abuse Services is determined based on the lesser of:

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

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

The Maximum Reimbursable Charge for covered services for medical services other than Mental Health and Substance Abuse Services is determined based on the lesser of:

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

The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule.

A Medicare based schedule will not be used in determining the Maximum Reimbursable Charge for:

- charges made by providers not participating in Medicare or that do not submit their Medicare ID with the claim;
- Covered Services for which Medicare has not established a rate; and

- the following Covered Services until such time as Cigna has implemented a Medicare-based schedule for them: certain ambulance services, treatment of end state renal disease, Home Health Care, Skilled Nursing Facility, and inpatient rehabilitation.

In these situations:

- The Maximum Reimbursable Charge is determined based on the lesser of:
  - the provider's normal charge for a similar service or supply; or
  - the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.
- There is no limitation on charges made by facilities or for charges for which there is not enough charge data in a geographic area to apply the Maximum Reimbursable Charge methodology.

All charges for Covered Services are subject to all other policy limitations and applicable coding and payment methodologies determined by Cigna.

Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS112 04-10
V1

Medicaid

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

HC-DFS16 04-10
V1

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies means or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury or disease.

HC-DFS113 04-10
V1

Medicare

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

HC-DFS17 04-10
V1

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement.

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

HC-DFS21 04-10
V1

Nurse

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

HC-DFS22 04-10
V1

Other Health Care Facility/Other Health Professional

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

Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS23 04-10
V1

Participating Provider

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

HC-DFS45 04-10
V1

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

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

HC-DFS412 01-11

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

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

HC-DFS25 04-10
V1

Primary Care Physician

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

HC-DFS40 04-10
V1

Psychologist

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

HC-DFS26 04-10
V1

Review Organization

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

HC-DFS30 04-10
V1

Sickness – For Medical Insurance

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

HC-DFS50 04-10
V1

Skilled Nursing Facility

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

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

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

HC-DFS31 04-10
V1

Specialist

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

HC-DFS33 04-10
V1

Terminal Illness

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

HC-DFS54 04-10
V1

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat an unforeseen condition requiring immediate medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, delivery beyond the 35th week of pregnancy, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

HC-DFS114 04-10
V1